

Pam
Med. miss



OUR MEDICAL TASK OVERSEAS

THE BOARD OF FOREIGN MISSIONS OF THE
PRESBYTERIAN CHURCH IN THE U.S.A.

FOREIGN MISSIONS AND OVERSEAS INTERCHURCH SERVICE

156 FIFTH AVENUE, NEW YORK 10, N. Y.

**MEDICAL COMMITTEE
OF FOREIGN BOARD**

WILLIAM J. BARNES, M.D. Englewood, New Jersey

MORRIS A. BOWIE, M.D. Philadelphia, Pennsylvania

E. FORREST BOYD, M.D. Los Angeles, California
(*Member of Board*)

HUGH CHAPLIN, M.D. New York City (Chairman)
(*Member of Board*)

MRS. FRANK C. HUGHSON, M.D. Albany, New York
(*Member of Board*)

HARTMAN A. LICHTWARDT, M.D. Detroit, Michigan

MISS T. MARGARET ADA MUTCH, R.N. New York City

PAUL S. RHOADS, M.D. Chicago, Illinois

MRS. VINCENT T. SHIPLEY, Philadelphia, Pennsylvania
(*Member of Board*)

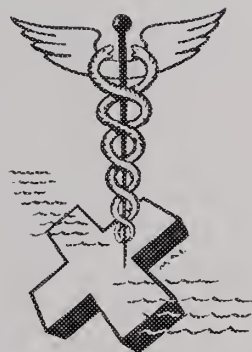
MISS RUTH C. WILLIAMS, R.N. New York City
(*Member of Board*)

Medical Department of Foreign Board

EDWARD M. DODD, M.D. Medical Secretary

WALTER J. K. CLOTHIER, M.D., Associate Medical Secretary

OUR MEDICAL TASK OVERSEAS



The Board of Foreign Missions of the Presbyterian Church in the U.S.A.

Foreign Missions and Overseas Interchurch Service

156 FIFTH AVENUE

NEW YORK 10, N. Y.

FOREWORD

DR. ROBERT E. SPEER, for some fifty years the great Secretary of the Foreign Board—speaking from his unparalleled experience—once said that if the Presbyterian Church had done nothing else in foreign missions but medical work, this alone would have been worth the cost of *all* the work, in money and force and time and toil, for the past century.

The purpose of this book is to give some idea of the scope and significance of the Christian medical work of our Church overseas which Dr. Speer considered so important. This work girdles the globe, touches all the major peoples of the world, meets all the major religions and social orders, including emphatically Communism, and has to do with almost all known disease conditions on this planet.

Though we have in mind particularly the Medical Emphasis Year of 1950, in which our Board is making a special appeal for this branch of our Christian World Mission, we also have in mind the longer range concerns of the medical work, which go far beyond any one year.

Some Basic Ideas

Why do we go?

A young American doctor in Tabriz, Iran, had finished a hernia operation. The brother of the patient, an intelligent and pleasant young Iranian army officer, had been present. After the operation the doctor invited the young officer over to the house for tea. Over the cheering little tea glasses, so typical of Iran, they talked congenially of this and that, near and far. Presently the Iranian came out with, "Now, doctor, we have become good friends. Tell me—just why are you people here?" He meant the missionaries.

Just why, indeed? That was a pertinent question and is the forever pertinent question. Why do Christian doctors and nurses go to Iran and India and Africa and China and South America?

The young man's question is undoubtedly asked by other thousands, in thought if not in word, wherever we go. Sometimes the question is asked with suspicion, sometimes in mere curiosity, sometimes with honest seeking. Why *do* we come there? The question has an answer. For that answer we go back to fundamentals.

Fundamentals

We begin with Christ. He was the Great Physician—both of the body and of the soul. His compassion for the sick and the suffering is the wellspring of medical missions—the ministry of healing of the Christian Church. He was also the Great Teacher, who opened men's minds to the truth. He healed and he taught. Often, but not always, he combined healing and teaching at the same time. He is our inspiration, our example, our authority, our continuing spiritual resource.

We therefore think of this Christian medical work both as an expression of our Christian faith and as a witness to it. It is the conviction of the love of God, revealed in Christ, which must have practical, tangible expression. It could not be Christianity without this. It also affords a witness. The cup of cold water in the name of the Master testifies to our faith in Him. And with the act of healing, there follows naturally the more definite teaching, which completes our mission. This is evangelism.

Compassion

How constantly is compassion spoken of in the life of the Master! "He was moved with compassion," and then did something to help.

The handbook of the Christian Medical Association of India, in a thoughtful re-study of their program says: "Again and again the records state that He was moved with compassion for them. Not only in the works of Jesus do we see this compassion exhibited, but it is shown in His teaching to be a vital manifestation of religion. One of the two great commandments enjoining love to one's neighbor, which cannot exist without love to God, was illustrated by the parable of the Good Samaritan, where we see a foreigner expending himself and his money on a wounded man, who had no other claim upon him except that he was a fellow man in distress."

Compassion is part of the answer to the question of our Iranian friend. Compassion includes the poor and the rich, the deserving and the undeserving, men and women, the responsive and the unresponsive, the good and the bad, of all races, creeds, colors, and castes.

A representative of our Board on a deputation visit to China three years ago, tells movingly of a patient in Douw Hospital, Peiping. She was a woman of the street, degraded, diseased, hopeless, in more ways than one. Yet the full skill and time and attention of Dr. Harold E. Henke and his associates were poured out for that woman. Could there be any more complete demonstration?

Surely we can feel that the ministry of healing is an essential and integral part of the world wide work of the Church, not just an adjunct. Not just an "opening wedge." To be sure, many times it has been an opening wedge but it is far more than this.

Opening the doors

When we speak of the "opening wedge," or, better, of the opening of doors, we are bringing up one of the special values and contributions of medical missions, particularly in the earlier days of any field of work. Again and again the doctor and the nurse have made the first friends and opened the first doors.

Even among the skeptical of our own country—the pagan Americans—this friendly function of Christian medical work is admitted. The writer well remembers certain conversations with such people on a Pacific liner returning from the Far East. Since he was known to be a medical missionary, the frequent remark was something like this: "We don't think much of missions. But the medical work is all right. We are all for that."

Hwaiyuan Station in China can never forget one signal happening, testifying to what the medical work meant in the early days of that station. This was a new undertaking, a pioneer piece of work. The Chinese of that community were very much of the old, conservative order of things in China. This was long before there was a Christian group. The children on the street shouted after one, "Foreign devil," and it was only a few years after the Boxer Uprising against foreigners.

Dr. Samuel Cochran was the doctor at Hope Hospital. He came down with typhus. Word got around in the town that he was critically ill, that they might lose this doctor friend. What was their response? A great company of them—

substantial people of the community—banded together, wound their way up to a shrine on Hwaiyuan Mountain, overlooking the city, and there pledged each a year of his life if the foreign doctor was restored to health. It was a serious business for them. They meant it.

Dr. Cochran did recover and went on to ever larger usefulness.

Prevention

Compassion, which is intelligently imaginative, includes prevention of disease, suffering and death. There is here an enormous field for planning and effort—far beyond what we are accomplishing.

To be sure, public health, on any large scale in a given country, is essentially a governmental responsibility. Be it said that the last two or three decades have seen great advances in public health work in the part of independent, colonial and mandated regimes.

The role of Christian medical missionaries in this preventive public health picture is to serve as stimulators, educators of the public, demonstrators on a small scale of what can be done, and always to co-operate where possible with constructive government programs. Hospitals can and do serve as health centers, working in co-operation with county or other regional units. Well baby clinics, which are widely popular, cannot only prevent trouble for the babies brought there but can teach a great deal to the community.

All over the Asiatic and African world, vaccination was early introduced by medical missionaries. Many a time it was the first definite item in preventive medicine and public health. And it is one of the things which has taken hold officially, so that now there is a considerable measure of vaccination.

Demonstration

One of the great demonstrations of what can now and then be done on a large scale in treatment and prevention was in Siam—now again called Thailand—immediately after the war. The story, familiar to many, bears repetition. Thailand is the rice granary of southeast Asia. It is a heavily malarial country. Before the war, the wide use of quinine helped to check malaria. With the war, the world supply of quinine, which came almost wholly from the East Indies, dried up for everyone except the occupying Japanese. Malaria, uncombated, again surged forward in Thailand. In hundreds of villages the rice farmers were too sick with malaria to be able to harvest the rice crop which was nearing harvest time. Great deprivation and even famine loomed ahead for Thailand and adjacent rice importing areas. Church World Service and the Presbyterian Board heard of the situation just before the veteran medical missionary, Dr. Edwin C. Cort, sailed back to Thailand. Church World Service bought up an enormous supply of atabrine, which has been developed in America during the war as the very effective substitute for quinine, and sent it out by Dr. Cort. The Thailand government was apprised and was on the dock, so to speak, when Dr. Cort arrived. That ship

was treated as a treasure ship, as indeed it was. The government health department and Dr. Cort mapped a great anti-malaria campaign through the rice country. It was eminently successful. The rice farmers got on their feet and went to work. The rice crop was saved, and probably tens of thousands of lives.

Later, the Thailand government expressed its official gratitude to Church World Service in a memorable ceremony at our Board rooms—"156." The Thailand Ambassador presented a beautiful gold and diamond studded plaque in grateful commemoration of what has been done for his country. Dr. Cort made an eloquent speech of acceptance in behalf of Church World Service.

Teaching

Long range compassionate concern cannot fail to realize the importance of training nationals in the Christian ministry of healing and prevention. Medical education, nurses training and the training of technicians and other workers were already well launched in several countries—notably Korea, China, and India—by the turn of the century.

Our Board has had a definite share in formal medical education at five places.—Severance Union Medical College, Korea; Cheeloo Medical School, China; Hackett Medical Center, China; Miraj Medical School, India; and Vellore Medical College, India.

In nearly all our fields of medical work, nurses' training schools—now advancing to *schools* of nursing—have been a most important contribution. Nursing, along with teaching, has been one of the first careers for women in the retarded countries. It has been a distinctively Christian contribution—even more than the education of doctors. We now have some twenty such schools, either in union undertakings or singlehanded in Korea, China, the Philippines, Thailand, India, Iran, Lebanon, West Africa, Brazil, Colombia, and Guatemala.

Nationals advancing

This all leads right into what the Nationals themselves are doing in medicine, apart from missions. The medical scene over there is very different than it was a generation ago. At the turn of the century there was very little of organized modern medicine in Asia, except for India under the British. Even as recently as the close of the first world war, countries like Thailand or Iran had almost nothing to show in the way of a health program, and only rudimentary efforts in medical education. The Philippines had progressed considerably under our government in twenty odd years. In Korea the Japanese, in their own fashion, had developed a good deal in the way of medical services and medical education. China, particularly, in the decade between 1927-1937 forged ahead in a most encouraging style until the Japanese invasion set everything back.

We think of ourselves as allies in all such advances. At the physical level we are all trying to do the same thing. We want to co-operate as much as possible in Government health programs and community health programs.

Continuing physical need

In spite of these advances the unmet physical need of Asia, Africa, and Latin America is still enormous. This applies particularly to the village people who are the overwhelming majority. But it also applies to the cities. It would be hard to find any city in Asia which has anywhere near as adequate medical care as New York, Cleveland, Denver, or Seattle.

Facing Communism

A new challenge has come upon us largely since the second world war. In most of our Asia fields, if not also in Africa, we are either in close contact with Communism or will be shortly. In this we have a searching challenge and a very potent one, and with it a corresponding opportunity.

The contact with Communism is closest in China, where so large a part of our work is now behind the "bamboo curtain." Our people there tell us—in the intermittent word which filters through—that one of the much blazoned propaganda statements of the Communists is that they are the only ones who are concerned for the common man. But in China, and elsewhere, they find Christian hospitals (and other institutions) notably caring for the common man. These hospitals have been doing this long before the Communists came on the scene and everybody there knew it.

The same sort of thing is true in Korea, where the country is split in half into a Communist-controlled north and an independent south—of the Philippines and Siam, which are fearful of the approach from China—of India, which Communism undoubtedly looks upon as its next great prize—and of Iran, where the outstanding national problem is the threat of giant Russia, next door. Even in the African Cameroun, which would seem to be distant and fairly safe, the preliminary tentacles of Communism are felt. Propagandists are at work in equatorial Africa and Communist writing percolates far and wide.

Toward world peace

If I did not believe that Christian Missions, including vitally the healing ministry, were one of the most important efforts toward world peace, I would lose one segment of my conviction and enthusiasm for this cause. Christian Missions do not seek so much the immediate implementation for peace, necessary though that is, as the long-range, fundamental bases of good will, understanding, brotherhood and spiritual light and leading. The inconspicuous, slow, intimate, multiplying, friendly impressions and influences of Christian hospitals go right to the grass roots. The Chinese or Indian or Korean or Iranian or African thinks in terms of another country partly in terms of the representatives of that country whom he has met. If these representatives are the staff of a kindly skillful, serving, life giving hospital—personified by Dr. X or Miss Y—he feels that much more kindly disposed toward that country. Nor can he wholly be carried away by wholesale propaganda. If you multiply all that by the thousands you *have* something.

Of the spirit

The most vital need is spiritual. Relieving suffering is Christlike. But merely keeping people alive is not enough. It falls short of working for a Christlike world. I do not know anyone who has better expressed what we have in mind than Dr. Barnes, the first Chairman of our Medical Committee, in an address given years ago in China:

"The consciousness of this divine office must characterize and determine the whole of our work. We cannot be satisfied with our hospitals until this spirit permeates every part of the day's routine. Un-Christ-like treatment of a patient by gateman, registrar, doctor, nurse, dispenser, or coolie, is a sacrilege in the House of God. To give loving help to body, mind and soul, as the Great Physician Himself would give it, is the purpose and justification of our work; and everyone who comes within our gates should be told in language which he can understand that, first of all, his happiness depends on a right relationship with his God, and that our deepest desire is to help him establish this relationship.

"This is our conception then of the relation of the medical department to Christian work in general. We realize with you that China's only hope is in renewed spirit, a renewal possible only through the abundant life of Christ in the lives of men and women, and our only purpose in doing our work day by day is to do what human beings can do in helping Christ to get into men's lives and to live and work there. We only ask of you that you expect as much of us. Expect us to be builders with you of the Church of Christ. Expect your hospital to be among the most prolific of the birthplaces of souls born into the new life of Christ, and as such regard it as being among the most important activities of the church organization and deserving of an adequate proportion of the church's working strength. See to it that no soul seeking physical help from your medical co-worker returns to his place without knowing why we are all here. Expect your medical and nurses' training schools to be training camps of soldiers of Christ, irrevocably committed to do battle for him. Expect the sum total of the medical influence in the community to be interpreted unmistakably as standing only for the establishment of Christ's Order."

Finally, we bring to mind that in Christ's last great commission, "Go ye into all the world", healing was included. "They shall lay hands on the sick and they shall recover." Daily this is being carried out by the Christian Church, working in His name, through the means at our command.

* * * * *

We can now look into what we of the Presbyterian family of the world Church are doing in obedience to this Commission and in fulfilling this promise. It would seem helpful to do this country by country—all too briefly to be sure—but trying to bring out individuality and strategy in the world-wide common task. We will begin with the Near East and proceed around the world.

SYRIA-LEBANON

This area is the "Triboro Bridge" for Europe, Asia and Africa. To the West is the Mediterranean, which Europe, since the days of Rome, has considered to be her Mare Nostrum. To the North is Turkey, whose history, and geography enmesh her with Europe and Russia. To the eastward are Iraq and Arabia. To the southward are Suez, Egypt, and Africa.

The geo-political implications of this area are multiform and explosive, involving the Arab world and Palestine, oil and the pipe-lines to the sea, European interests and rivalries, Russia and Communism.

These two countries, which have been set up separately only since the second World War, are essentially part and parcel of the whole Arab World. They are predominantly Moslem in religion, though in the Lebanon the Moslem and non-Moslem populations are nearly equal. In our work we have kept them administratively together.

Religiously the picture is complex and confusing.—Islam predominates. But there is a minority medley of smaller groups,—the numerous old, fragmented and more or less formalized Christian sects besides the newer Protestant group, Jews, Druzes, devil-worshippers, and what-not. Religion has been a hereditary, racial, socio-political matter. The relationship between Christian and Moslem has been thoroughly bedevilled—first, historically, by the Crusades, which to the Moslems were wanton, cruel, disrupting "Christian" aggressions—then by the old unappealing, divisive Christian sects—and over-all by the imperialistic politics of European "Christian" nations.

Into this welter of politics, and peoples and religions—antipathies new and old—and pressure groups in all directions—comes the simple, non-political, unselfish truly Christian mission hospital. It can cut the Gordian Knot, as few influences can do.

The medical background, in which we work, ranges all the way from the most primitive, staunchly Moslem-Bedouins of the desert, to highly qualified graduates of the American University Medical School in Beirut.

Private hospitals, particularly in Lebanon, are multiplying rapidly, as the public awakens to the advantages of medical care. Beirut, by far the best provided, has something like 1,000 hospital beds among several university, government, private and Church hospitals,—in a city of 233,970 population. Tripoli, the "second" city of Lebanon, besides our excellent mission hospital of 100 beds, has a government hospital of 75 beds and about fifteen private ventures totalling another 200 beds. Syria is not nearly as well off as Lebanon. And the more one gets out in the villages, where most of the people live, the less medical care there is, till it dwindles to nothing for most of the population.

We have one general hospital in Lebanon, at Tripoli, and another in Syria, at Deir-ez-Zor. There is also the Hamlin Memorial Tuberculosis Sanatorium near Beirut.

The Tripoli Hospital has done wonders with a rather old building. Dr. and Mrs. Harry Boyes are indefatigable and devoted workers. Dr. Boyes is director, surgeon, teacher of interns and nurses, and public relations man. Mrs. Boyes is business manager, treasurer, dietitian, hostess. They are an unusual team. Between them they have developed an institution which is the admiration of lay and medical visitors, for its spirit, efficiency and warm evangelistic work. It means a good deal that the young medical graduates of the high-grade medical schools in Beirut seek out this hospital for internship.

Nursing, through a training school staffed by nationals, has been a splendid contribution of this hospital, especially so in a region where the Moslem system kept women down. As in Iran, the introduction of nursing as a skilled, honorable and Christian profession has been pioneer work.

The Deir-ez-Zor Hospital way out in the border reaches of the Euphrates, deals with an entirely different setting. This is a comparatively primitive desert town,—almost solidly Moslem—surrounded by the Bedouin river villages and Bedouin nomads. In this setting it could not be anything but hard, slow work. Dr. and Mrs. Bertsch, who went there in January 1947, though making a fine start on the good foundations laid by others, are really starting very much on their own, as the hospital was taken over by the military during World War II; and there has been a hiatus of several years between American doctors. Those who had gone before included Dr. E. H. Hudson, Dr. Susan Crosley, Miss Ida Manley, R.N., Miss Clara Peters, R.N. and Dr. Glenn Rost and Mrs. Rost, R.N.

Dr. Albert Bertsch in the Deir-ez-Zor, Syria, Hospital,—a desert post on the Euphrates River.





Dr. Henry Boyes, Tripoli, Lebanon, with a patient whose visitors evidently represent desert and city, judging from their headdress.

The Hamlin Tuberculosis Sanatorium is another "pilot" institution. For many years it was the only institution of its kind in all that part of the Near East, where tuberculosis is common. Now there are imitators who are also taking up the problem. Dr. Nucho, Sr. deserves great credit for the work done here. And the future of the institution is promising in the very capable hands of his son, Dr. Charles Nucho.

It is a distressing fact that this valuable, teaching, institution actually had to get along for a number of years recently without an X-ray machine. Through the kind offices of a friend, a fluoroscope was obtained from the United States Army in Egypt. Can we imagine a tuberculosis hospital getting along without an X-ray machine!

It is stated by a competent and experienced American observer that the major part of the medical advance of Syria and Lebanon can be laid to the credit of medical missions. And the hospitals have been true and winsome witnesses to Christ.

As we look forward in the Syria-Lebanon Mission, there are no revolutionary moves contemplated. We must carry forward, with our prayers, our recruits and our gifts, and the work of these three hospitals. The most recent recruits, who sailed in the fall of 1949, are Dr. and Mrs. William Shoemaker.

IRAN

Some years ago, midway between the two wars, a traveler, who had known Iran under the old order, revisited the country under the changing new order. He was much impressed with the progress being made. Said he:—"If I were designing a coat of arms for modern Iran it would be a Chevrolet truck rampant over a donkey couchant, and in the distance a camel 'fade-out'!" He would now have to add an airplane ascendant.

Until well after the first World War, Iran continued to be a notoriously backward, isolated, decrepit country. The general cast of life was much what it had been for centuries past. The ubiquitous little donkey and ox-cart were still the only means of short-haul "trucking". The camel caravans were still the prevailing long-haul. Real all-weather roads there were none. One shifted with the seasons from billowing dust to bedevilling mud.

Social order

The age-old social structure of Iran was, and still is, feudal. The mass of the population lived at poverty level in thousands of small mud-walled villages. Most of these villages were the property of absentee land-owners, in distant cities. The peasants were hardly better than serfs.—This is obviously fertile soil for Communism.

Government

The autocratic government was a decadent, corrupt, monarchy. The popular attitude toward government was one of inertia, futility and cynicism. "It is Iran", they would say, with a shrug, and let it go at that.

Islam

Dominating the whole social, political, and religious order was Islam, static and intolerant. The non-Moslem minorities of Iran are hardly more than 5%. An ambitious and rebellious young Moslem, who was dilating to me on the miserable state of Iran at the time of the first World War, summed it all up by exclaiming passionately: "It is our rascally Mullahs (Moslem religious hierarchy) who hold us back! It is their fault."

The old order medically

One of the most far-reaching of the medical influences of Islam is its ingrained fatalism. Everything has been foreordained by Allah. Man is a puppet. Sickness and death are decreed. And what shall one do! If the children have diphtheria, why do anything? They will die or get well according to the will of Allah. If your wife is wasting away with something why go to the doctor! It is all settled one way or the other.—Besides, wives are easily replaced!

The old style medicine was a mixture of traditional ideas,—a few with real value—superstitions, charms, old wives meddlings, and Koranic traditions.

Aside from a small company of medical missionaries, a smaller group of emigres from Russia or elsewhere, a handful of foreign-trained Iranians, there were no modern trained doctors in Iran.

The government took no interest in the health problems of the people. There was no health department and no public health program.

Endemic and epidemic diseases ran their untroubled course. Typhoid, malaria, and smallpox were very prevalent. Cholera swept in every once in a while with devastating and terrifying results. Trachoma and cataract were common. Bladder stone was one of the commonest surgical conditions. The incidence of tuberculosis was surprisingly high for a country of abundant sunshine. Infant mortality was appalling. Some years ago the Meshed Hospital staff estimated that in that region 80% of the children died before reaching five years of age.

Progress

With the 1920's, new life swept in on Iran. In terms of transportation, automobiles began emerging here and there and then rapidly multiplying. For long trips the little Chevrolet truck, crowded beyond credibility with passengers and goods, became the standard means. The camel caravans began dwindling, though it will be a long while before the villager can dispense with his donkey. Airplanes began appearing in the skies. The railroad stage was, for a time, skipped.

In terms of government a powerful figure came on the stage—Reza Pahlavi. He rose from the Army ranks by sheer force and ability—and also by default, let us say,—until he made himself supreme and finally crowned himself Shah (King or Emperor). Reza Shah was progressive, aggressive and dictatorial. Under his powerful hand Iran advanced far into the modern world. Good roads and bridges were built far and wide. The marauding bands of Kurds and bandits were put down. The leading cities were put through a face-lifting as to streets and public buildings. Education was pushed at all levels. The Moslem hierarchy was curbed and demoted, though Islam was still recognized as the state religion. Under him Iran travelled at least part of the road travelled by Turkey under the great Kemal Atatürk.

Medical progress

Medical progress went with all this development. Several good hospitals came into being in Teheran and elsewhere. Teheran University Medical School was greatly strengthened. At the present writing there are something over a hundred graduates of this medical school in the United States taking advanced study in various specialties. They seem to hold their own in hospital internships and medical courses. The government began taking an interest in health and its Ministry of Health has now become an important part of the government. Yet it will take the combined efforts of this ministry and of the medical profession a long while before they can catch up on the needs of the country. In other words, there is plenty for us all to do.

Medical missions

Christian medical work came into Iran to stay in the latter part of the last century. Dr. Joseph Cochran, the best known of that pioneer generation of medical missionaries, began his notable career of a quarter of a century in 1880. But it was not till after the turn of the century that the medical work really gathered momentum. In the first World War period we had thriving work in seven of the leading cities of the north and west.

One longs for space to personalize our Iran medical work. There have been notable and colorful figures among them and a high order of devotion and effectiveness. The name of Dr. William S. Vanneman was one to conjure with on Tabriz. Urumia Station (later called Rezayeh, and afterwards closed) had varied and dramatic experiences during World War I. The wartime story of Dr. Harry P. Packard and his associates Dr. W. P. Ellis and Miss Mary E. Burgess, R.N. is an epic in itself. The development of Meshed Hospital by Dr. Rolla E. Hoffman and Dr. Hartman A. Lichtwardt, and Miss Mabel Nelson, R.N. in the early fanatical days, and its carrying on now by Dr. Joseph P. Cochran, Dr. Thomas Murray, and Miss Janet Fulton, R.N. and Miss Mary A. Harvey, R.N. was a notable and continuing story. Teheran Hospital, which has been closed since the United States Army took it over in the last war, was doing a great piece of work under Dr. Philip C. McDowell, Dr. Edward Blair, and Miss Grace Taillie, R.N. Tabriz Hospital under Dr. Charles W. Lamme, Miss Jean Wells, R.N. and Miss Frances Wooding, R.N. and now also Dr. Ashton T. Stewart, and Miss Emma A. Degner, R.N. Resht Hospital under the late Dr. John Frame and Mrs. Adelaide K. Frame, M.D. and latterly Dr. Rolla E. Hoffman, Miss Eunice Baber, R.N. and Miss Gertrude E. Benz. Hamadan Hospital under Dr. J. Arthur Funk, and for all too brief a time, Dr. Joseph Cook, and now Dr. Mary D. Zoeckler, Dr. John Frame, Jr. and Miss Wilma Pease, R.N. Kermanshah Hospital with Dr. Russel Bussdicker and now also Dr. Frances Zoeckler, Miss Ellen Nicholson, R.N. and Miss Gertrude Winkelman, R. N. have all had their individuality and are making invaluable contributions.

Distinctive contributions

The distinctive contributions of Christian medical work in Iran might be summarized as follows:—

1. It has helped to make Christianity recognized and appreciable as a practical service to humankind. The typical old style Mohammedanism sorely lacked this. They talked religion freely; but there was no implementation with human social values.

2. Honesty and truth have been held up where they could be seen and where they counted. One of the characteristic pleas or testimonies in coming to a Mission hospital is that there they are dealt with honestly and told the truth.

3. There has been a considerable educative contribution in what modern medicine can do in therapeutic and preventive ways. Smallpox vaccination, for ex-

ample, was introduced and given considerable vogue by medical missionaries, long before the government or anyone else took it up.

4. Nursing has been initiated, as in so many other countries of Asia, Africa and Latin America. There was absolutely nothing of the kind under the old Moslem-dominated order. Women were too much the secluded and suppressed half. Nursing and teaching have become pioneers in careers for women, through missions.

5. Women patients were cared for and respected just as much as men patients. This was a most salutary object lesson in a Moslem society.

6. High-grade medical care has been furnished the provinces and villages, whereas the best of the Iranian profession concentrates in Teheran.

7. Definite, direct, evangelism has had a natural and friendly opportunity in clinics and hospitals and in itinerating and family contacts.

Among the assets are:—

1. The good-will and confidence of the people. This is noteworthy.
2. Well-trained American personnel. We still lead.
3. A devoted Christian spirit and a Christian purpose. This is priceless.
4. A fairly good plant and equipment for the most part.

Among the liabilities or challenges are:—

1. The advancing standards and demands of the present time in relation to inadequate funds and aging plants and equipment. There is great need for renovation of all of the hospitals.

2. The need for moral leadership in the rapidly developing medical profession of Iran. It is securing professional skills. It is not necessarily achieving an adequate ethic. There is no Christian tradition behind it as there is with the profession in the west.

3. This developing profession competes on the level of specialized skill. Our staffs cannot indefinitely be as *general* as they have been and hold their own in this changing environment.

4. The resurgence of Islam,—partly as a political national defense against Communism.

5. As Communism looms on the scene, with its vehement and often beguiling insistence that it is the only ideology which is concerned with the common man, the Christian hospital in Iran has a unique opportunity to demonstrate how Christianity cares for the common man, woman and child and has done so long before Communism appeared.

The Tabriz Hospital, Iran, was one of the pioneers in nurse training in the Near East. This was graduation day in 1949.



INDIA

India is going through the throes of a rebirth. From the old India have come two nations—the new India and Pakistan.

The old, inclusive India, under Britain, was a veritable subcontinent, teeming with crowded population, kaleidoscopic with races, religions and castes, seething with restive life and laboring with staggering problems—always absorbingly interesting.

The new India goes on with most of this. One problem, the divisiveness and friction between Hindus and Moslems, has been decreased, in that the Moslems—a large minority in "old" India—now have their own country. By mass flight, migration and exchange of the two peoples, there are many millions fewer Moslems in India and many millions fewer Hindus in Pakistan than there were. But otherwise most of the basic problems of "old" India carry over into the new, including the staggering over-population and health problems. The two are closely related.

The violent, tragic period of partition after August 15, 1947, their independence day, is over. Tensions between the two nations remain but they have their chance for peaceful and constructive relations.

India is fortunate in such great leaders as Jawaharlal Nehru. Ghandi is no more but his mantle, in large measure, has fallen upon these able leaders who have succeeded him. Theirs is a stupendous task. We of the Christian Church long to help wherever we can.

Backgrounds

India is an extraordinarily complex country. So the background for Christian medical work is probably more complex and involved than in any other country in which we are at work. Only a brief discussion is possible here.

We have mentioned over-population—at least over-population in comparison to present economic means. One is struck with this at every turn. The traveler meets it at the railroad station or the hotel, where thin and undernourished porters scramble and struggle for his baggage. Beggars abound. They all typify the dire economic struggle of life.

Medical workers come up against this economic situation constantly. Much of the human trouble with which they deal involves poverty. The people, especially the village people, are underfed. They are near the starvation level in average times and can easily slip over into starvation in unfavorable times. They cannot afford medical care. Modern medicines are beyond them. They cannot pay for hospitalization. They have no such thing as health insurance. Malnutrition and diseases, which flourish on lack of vitamins and resistance, are the order of the day. One's heart aches for these people in the daily clinic.

The medical problems of India can never be wholly solved apart from the

Vellore Christian Medical College, India, is well housed and picturesquely located. This is the all-India Christian Medical College in which some 38 British and American groups unite.



economic problems. But this is no cause for despair. Much can be done even now. A villager, who is freed from his depleting parasites or malaria, can resume production. The family can again eat. The wife and mother, who is such an essential part of the economy, can be turned into an asset instead of a liability. The only surviving son of the family can be healed, and the drain of payments to priests and shrines and native "doctors" relieved.

Religious background

As we will find in country after country, the religious beliefs and practices underlie and condition medical concepts and practices to an extraordinary degree—far more than we of the west can realize. Religion permeates all of daily life, and dictates much of the ideas concerning disease and medical care.

For example, the abhorrence of taking life—a good thing up to a certain point—which is such a basic tenet of Hinduism (as also of Buddhism) means that the Hindu does not eat meat. He is automatically deprived of that whole range of protein in his dietary. This is a real loss.

Even more important are the implications as to bacteria and pests of all kinds. The Hindu will not kill the malaria-bearing mosquito. This complicates public health problems enormously, in a malaria-ridden land.

Some years ago Dr. Robert H. H. Goheen, when head of St. Luke's Hospital in Vengurla, India, was faced with the first indications of an epidemic of plague. The rates were beginning to die and fall. Rats get the plague first and then pass it on, via the rat flea, to humans. But the devout Hindus of the community—at least the elders—were altogether opposed to killing rats. They depended on charms and incantations and whatever their priests said.

The more enlightened Health Department at Calcutta—British trained—was ready to provide rat poison in suitable form, if people would use it. Dr. Goheen hit upon the young idea. He talked the matter up in the mission boys' school and in the two other rival boys' schools of the community. He set them

all a community project. Would they distribute the rat poison through Vengurla? They responded with a will. They would. It became a matter of keen rivalry between the three schools. The rat poison was effectively distributed. And the epidemic was cut short.

Time and again the people themselves have asked the question, "Why do the Christians get along so well in the cholera and plague epidemics when we die?" The answer, slowly percolating, is that the Christians, unhampered by Hindu inhibitions and all the medical nonsense which goes with it, accept scientific ideas and follow the modern doctors' advice. They use the available vaccines. They boil their drinking water and they exterminate rats. The results stand out.

Caste

The caste system has thrown its blight over India in many ways. It has cramped and frustrated and made life sterile and fatalistic. Within the socio-religious structure there was no chance to rise. One's status in life was set for life. The greatest escape and release, incidentally, was through Christianity.

The new constitution of India prohibits the disabilities of caste. This is a splendid step forward. The actual implementation of this throughout the country will be a long, hard struggle against the forces of reaction and privilege and inertia, including the religious Brahmin hierarchy. In the end the new constitution and the forces of progress and liberalism will, we believe, win out. For the present there is still plenty of the caste system holding over to continue those problems. For some time to come the outcaste, the submerged untouchable, will be at a health disadvantage.

Purdah

Along with all this has gone purdah—or, literally, the veil. Purdah includes not only the veiling of women outside their homes but the whole secluded, suppressed life to which they are consigned. Both Hindus and Moslems have this practice. The women are very much the lesser half, or *have* been. Their day is at hand. The new order is changing from purdah to freedom. But the change necessarily comes slowly, especially in the villages.

Purdah has been a tragic ill-health factor. The women have had the least fresh air and the least exercise and a lesser share of food. Ills attendant upon these factors are to be expected. Psychologically they have been repressed and man-dominated and frustrated. Women doctors in India can speak sadly and



A ward in Miraj Hospital, India—one of the greatest of Mission hospitals and medical centers.

eloquently of the physical and emotional results. Katherine Mayo, in writing "Mother India" gave a one-sided picture, which was deeply resented. She omitted the progress being made and much less on the credit side. But the medical picture she gave of the old order, as it applied to women, was not essentially controverted.

I well remember Dr. Adelaide Woodard, an experienced and devoted medical missionary, who deeply loved India, saying with tears in her eyes—"India is a sad, sad country." She was thinking especially of the thousands of women she had cared for in clinic, home and hospital.

It made me think of a group of Iranian Moslem women, who were inveighing against their lot in life as compared with Western women. One of them summed it up by saying—"Our prophet (i.e., Mohammed) forgot us."

In India both the Hindu and the Moslem systems have borne down heavily on the women. Happily there is hope ahead.

The Christian hospital cuts right across all these divisions and barriers. There is no superior caste and no superior sex in a mission hospital. That has come to be well recognized.

Some years ago when an enlightened Rajah in the Miraj region wished to set up rest houses in his domain, which would be open to all without any distinction, the clearest and most convincing announcement he could think of was that people would be received and treated there "just as at the hospital of Dr. Wanless and Dr. Vail at Miraj."

Indigenous medical facilities

Every land has its old style medicine, which has evolved over the centuries. Of the indigenous medicine of India, Dr. Goheen, out of his rich experience gives a description: "The practice of medicine is carried on by many different cults. There is the village *vaidya*, whose training is usually an hereditary affair. Herbs, fruits, leaves and roots are used, some of them being very potent agents, such as nux vomica, atropa belladonna, datura stramonium, etc. Metallic mercury, gold, arsenic, powdered pearls, are some of the galenicals that have long been used. More recently potassium iodid, sodium bicarbonate, etc., have been added. In fact the enterprising young *vaidya* of today may conduct a dispensary with shelves stocked with many of the pharmaceuticals of the West, even though his knowledge of English may be extremely limited.

The lucky patient who comes to the Fatehgarh Hospital by modern means of transportation. Dr. Carl Taylor, Dr. Lois Visscher and Juanita Owen, R. N. are on hand.



"Religious rites or *mantrams* and *charms* have their place in these practices, particularly if the patient or his family belong to the old order or to the ignorant classes."

The need

A glimpse of physical need in India villages—a glimpse which could be repeated in tens of thousands of villages in Asia—comes from Dr. Paul S. Rhoads of Chicago in a visit to Miraj:

"I went out with Mr. Nelson, the visiting missionary, and an interne and two medical students in one of their village expeditions. This experience I would not have missed for anything. I had never believed that people lived under such conditions. The need of those people for medical care, sanitation, *food* and a new outlook is appalling.

Bhore report

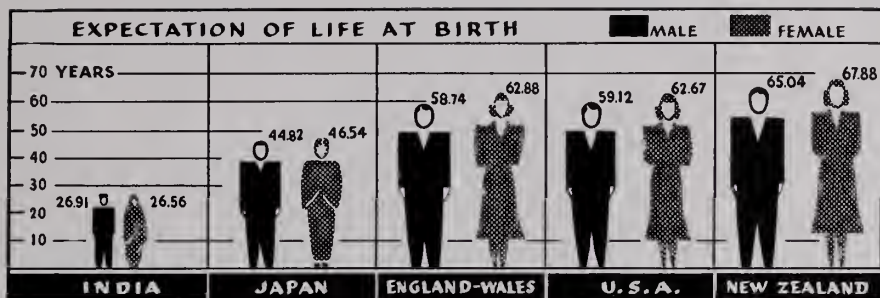
For a comprehensive picture of the medical situation we turn to a unique, official study made a few years ago by an eminent group—nineteen Indians and five Europeans, including one medical missionary—which is known as the Bhore report, after its distinguished chairman. This was a careful factual over-all study of medical conditions and facilities in "British" India. Though the situation has been drastically changed by the partition of the country, the main outlines, and the essential significance, of the Bhore report still stand—especially if one includes Pakistan in one's thinking. We can draw on only a few excerpts.

For example, the number of licensed medical practitioners, for "British" India, is given as one to 6,300 people. Our ratio is about one to 750. As this figure did not include the old princely, or native, states, where conditions generally speaking were decidedly more backward, the over-all figure is worse than this. Moreover, India needs a *higher* ratio of doctors than we do, because there is more sickness in India. Also probably 70-75 of these doctors practice in urban centers, whereas the predominance of village population is more than the reverse of this ratio.

As to hospital facilities we will take one sampling:

"In view of the wide prevalence in India of many of the special conditions of ill-health and disability, the hospital accommodation available in each case is quite insufficient to meet the requirements of the country. We may take three instances. The total number of beds available for tuberculosis patients is about 6,000 while estimates based on standards considered necessary elsewhere will place India's requirements at about half to one and a half million beds. A conservative estimate of the country's needs in respect to hospital accommodations for mental patients places the figure in the neighborhood of 800,000 while the available number of beds (including the Indian States) is a little over 10,000. As regards eye hospitals the existing provision is less than 1,000 beds."

The figures it gives as to life expectancy in years are striking:



There is still much more that could be brought out as to the medical needs of India—not only quantitatively, but, fully as important, *qualitatively*. But what we have given is enough to bring out the point.

The place of medical missions

In the sight of all this, where do we come in? Perhaps we can venture a few general points.

1. There is still a vast, uncared for health problem in India, especially in the villages. There is plenty and more than plenty for government and private agencies and missions to do. The utmost of combined efforts will not overtake the needs in this generation, as far as one can judge.

2. We are working with a progressive, advancing situation. Enlightened forces are at work. The government has a medical program. And we can expect this program to be implemented step by step.

3. It behooves us to inform ourselves of this program, to become acquainted with and keep in touch with Indian medical leaders, to co-operate where we can.

4. We have our distinctive contribution to make.

Before we discuss this distinctive contribution, let us look at a few statistics. The most recent available figures on Christian medical forces in India are the following:

FOREIGN

Doctors	Men 120; Women 148	268
Nurses		308
Qualified Pharmacists		12
Qualified Technicians		10

NATIONAL

Doctors	Men 246; Women 199	445**
Nurses	" 231 " 807	1,038
Qualified Dispensers	" 298 " 132	430
Qualified Laboratory Technicians	" 92 " 35	127
Medical Students	Men 102; Women 203	305**

* * Fifty-nine are of the M.B.B.S. grade (the equivalent of our M.D.).

Qualitatively these people mean a great deal more than one might guess from their numbers. When we say qualitatively we have in mind the whole range



One of the most compact and useful of Mission dispensaries was developed by Dr. Douglas N. Forman at Allahabad, India.



The family is a very important part of the picture in a hospital, in the Orient, as in this little scene from Fatehgarh, India.

of medical service and Christian impact. Here is an incident which illustrates much of this.

A distinguished Bombay surgeon had heard such fine things about Dr. Norma Dunning Farmers' work at Kolhapur Hospital, that it occurred to him to go and see what made that place "tick" the way it did. He spent a day visiting and observing through the clinic, the wards, the operating room. It was just a usual hospital day, no staged affair. At the end of the day, when he took his leave, he said to Dr. Farmer something like this:

"Do you know what incident has impressed me more than anything else all day?"

When she said "no", he went on:—"It was in the operating room. A nurse was bringing you a tray full of sterilized instruments. She was behind you, and, as far as she knew, not observed by me either. An instrument fell off the sterile tray and without a moment's hesitation she took that instrument back to the sterilizer. It was entirely on her own. If it had been one of our (non-Christian) nurses, she would have sneaked that instrument back on to the sterile tray, if she had thought that she could get away with it.—"Now tell me" he said, "How do you do it? How do you produce this in your nurses?"

Dr. Farmer had a great chance to tell him just how it was done. The how and why of that small incident has volumes of significance for this world.

Tuberculosis

Christian medical work in India, as elsewhere, has led the way in certain neglected fields of need, notably in tuberculosis and leprosy.

Tuberculosis is a major scourge in India, as in so much of Asia, and, as already noted from the Bhoire report, the provisions for its care are quite inadequate. The lead in this work has been from the missions. One of the public health

experts who went out with the Layman's Inquiry in the early 1930's told the writer that much the best T. B. work, qualitatively and quantitatively, was being done by the missions.

We are proud of the Wanless tuberculosis sanatorium, near Miraj, in Western India, south of Bombay. This was the last signal achievement of that great surgeon and great Christian, Sir William Wanless. He had already developed the greatest mission hospital in India. And he had created the only Christian medical school for men in India. In his last year or two of service, when physically he was broken, he started the T. B. sanatorium. When the writer was in Miraj in 1930, two small bungalows on the new property, if he remembers rightly, were the sanatorium in embryo. Dr. Wanless with the last ounce of his ebbing strength was appealing for funds. Before he died it was well launched.

From this small start the place grew like the green bay tree, and wholly from fees from patients and Indian gifts. No money from America has gone into this plant. It is now one of the outstanding T. B. institutions of the country, with a bed capacity of over two hundred and an active modern program. It is in charge of an Indian, Dr. Samuel.

Several others of our Board's doctors—notably Dr. Goheen at Vengurla—have developed smaller sanatoria, which made their very worthwhile contributions.

Leprosy

The Christian forces in India pioneered perhaps even more in the field of leprosy. They were the first to come to the rescue of the unfortunates, afflicted with this disease who were so often literally outcast. And this was begun in the days when there was no specific treatment for leprosy. Good housing, adequate clothing, good food, kindness, comfort, cleanliness and general medical care can accomplish a good deal for leprosy, even without chalmoogra oil or the newer drugs—Diasone and Promin. So the leprosaria at Allahabad, under the famous Sam Higginbottom, at Vengurla and at Miraj, and elsewhere, did their part in physical care and in expressing the compassion of Christian people.

Hospitals

The medical work of our Board and Missions in India has centered at seven general hospitals and two independent dispensaries.

In the Punjab—the northern province which has been split by the partitioning off of Pakistan—we have two women's hospitals. One of these is at Ambala, under Dr. Ivanoel Gibbins, Miss Leila Clark, R. N., and Miss Estelle Clark, R. N., and their Indian associates. The other is at Ferozepur under Dr. Dorothy Ferris and Miss Isabella C. Ross, R. N. It is for these hospitals that the Women's Jubilee Fund was raised. And it is particularly for these hospitals that Mrs. Helen Saulsbury has made her moving appeals to the home Church.

Whole chapters should be devoted to the extraordinary services of these hos-



Prevention is increasingly the order of the day, in India and elsewhere.

pitals in the terrible Hindu-Moslem-Sikh outbreak of 1947. The half has not been told.

We should link in here an institution which has great significance for the medical mission program in all north India. This is the Ludhiana Medical School in the Punjab. Though our Board has had no official connection with this school, our missions and individual medical missionaries have co-operated with it in many ways. This school is now facing the same crisis which Miraj and Vellore have faced, as we will see presently. Our group in the northern part of India have urgently recommended that our Board assume a share in the support and development of this school. And a substantial sum is proposed for it in the Medical Emphasis Year Appeal.

In the adjoining area of our North India Mission we have two hospitals and two independent dispensaries. The Fatehgarh Hospital, a general hospital, still keeps warm the memory of beloved Dr. Adelaide Woodard and her close friend, Miss Sarah McRobbie, R. N. The American staff there now consists of Dr. Carl Taylor, Dr. Lois Visscher and Miss Juanita Owen, R. N. and Miss Ida Johnston, R. N. This is a hospital which has had a checkered career, with many and interrupting vicissitudes of staff. It now has the strongest total staff in its history and can again move forward.

Kasganj is a compact little hospital fairly bursting its seams with activity, particularly with its obstetrical service. We associate its past with Dr. Hildreth Caldwell and more recently with Dr. Harriet Davies, who retired in 1947. At present the only Americans on the staff are Miss Julia F. Murray and Miss Elsie Gleason who are faithfully holding the fort.

The Jumna Dispensaries, at Allahabad, are unique. They have no attached

Dr. Marian Moore and her roadside clinic, India.



hospital. For referrals for hospital care they must depend chiefly on the municipal hospital. One is on the campus of the Ewing Christian College. The other is across the Jumna River with the Agricultural Institute, founded and made famous by Dr. Sam Higginbottom. We associate the Jumna Dispensaries particularly with the creative hand of Dr. Douglas Forman, who made them so well known, and following him, with Dr. Mabell Hayes.

In the Western India Mission, we have the Miraj Hospital, founded by Dr. Wanless and made famous by him and by his able and beloved successor, Dr. Vail, with its branch hospitals and the Kolhapur and Vengurla hospitals. Kolhapur, a woman's hospital, where the tradition of Dr. Victoria MacArthur still lingers, we have the active colorful program carried on so efficiently by Dr. Norma Dunning Farmer and Miss Florence Shafer, R. N., and Miss Antoniette Meuttmann, R. N., Vengurla, which at the moment has no foreign staff, had an unusually strong history in the days of Dr. R. H. H. Goheen and later of Dr. Eugene Evans. Miraj is our largest hospital. Last year it took care of 4,000 in patients and 50,000 outpatients.

Medical education

Medical education in India, as elsewhere, should come in for special attention. It is the heart of our grand strategy. In India, as elsewhere, we want to develop able, devoted, *Christian* doctors and nurses who will carry on. They are the hope of the future. They must increase, and we must eventually decrease.

Miraj Medical School, south of Bombay, is the embodiment of Dr. Wanless' vision of more than fifty years ago. Beginning modestly with a handful of students, then with a class of twenty or so, admitted every other year, he created a

school which has been invaluable in the Christian and medical life of India. It has been the only medical school for men under Christian auspices in all India—in fact, the only one between China and Syria-Lebanon. Its graduates have been the mainstay of mission hospitals throughout India and even in adjoining countries. One or two of their men have worked with Dr. Paul Harrison in Arabia.

The writer met up with one of the distant outreaches of Miraj, many years ago on the semi-desert, far-confines of Iran. It was, to be exact, at the nondescript border village of Dozdab, where the narrow-gage, single-track railroad used to take off across the waste of Baluchistan to India. There was a humbly-housed little hospital under one of the smaller missions. The one and only doctor was a Miraj man—doing a fine job in this jumping off place from no-man's land. When he heard of my connection and that presently I would be in Miraj he was all aglow. There was no mistaking what Miraj meant to him or that Dr. Wanless and Dr. Vail were his patron saints.

Now we come to the fork in the road. Miraj is a medical *school*, not a medical *college*. India has had these two levels of medical education. The medical college corresponds to our standard M. D. medical schools or colleges, whichever we call them. The medical *school* in India is a cut below this. The graduates, though with good practical training and accredited as licensed practitioners, are just below the top level.

It is now the step-by-step policy of the provinces in India to raise medical schools to the medical college level or close them out. Miraj was faced with these alternatives and struggled with the problem for several years, trying to find a way to up-grade itself to the desired level. But it did not seem feasible. Miraj is a single-denomination institution. A medical college of high grade practically has to have the broader supporting base of a union interdenominational undertaking, such as Vellore, to which we will come in a moment.

After much study and thought in Miraj and at Board headquarters, the decision was to give up the medical school and convert Miraj into a post-graduate teaching center, working in close co-operation with Vellore. This would entail much less expense and much less staff; and the program could evolve as we could manage, without rapidly having to step up to extremely difficult official requirements. The logical lines of special emphasis would be in what Miraj already is strong—surgery, chest work, tuberculosis, leprosy, rural work—perhaps later also psychiatry. We will expect to offer courses and residencies in these lines.

Though it is little short of tragic that the medical school has to be given up when it is still so greatly needed, we can rise to the challenge of this alternative teaching program, which has splendid possibilities. A substantial allotment of our medical emphasis year money will go into this program.

When we come to the Vellore Christian Medical College, we come to one of the finest united undertakings of Christian Missions. For years it was increasingly apparent that medical schools at Miraj under Drs. Wanless and Vail, at Ludhiana in the Punjab, under Dr. Edith Brown, and the Vellore Women's Medi-

cal School under Dr. Ida Scudder, invaluable and indispensable though they were, were not enough. They were not advancing sufficiently, because of imitations of force and funds. The University Medical Colleges were passing them in their standard of work. Moreover, as noted above, the provincial governments, which manage medical practice much as our states do, were raising standards and requirements all around. But it was hard for the several missions to rise to the occasion, with the necessary increases in costs and staff.

Then the situation was precipitated by the action of the Madras Government, where Vellore is located. This action established the higher medical college level as the only one for the province, with the medical schools allowed a time limit within which to raise their standards or close up. The Christian forces of India were brought face to face with a crisis. Hitherto, baffled by the task of creating a new high-grade union medical college, they faced the possibility of *loss* of ground and loss of one of the best potential possibilities for a high-grade medical college. Much prayerful and searching deliberation followed. The final conclusion was to get together on Vellore, already a strongly established medical school under Dr. Ida Scudder, and make that the all-India, co-educational, united medical college for all the Christian groups. This was during the war when the Far East was in eclipse. India was open to work and very much to the fore. Various missions and board groups accepted the challenge and went to work.

The result, which is still very much in the making, and still at a critical state, has been heartening. Forty odd mission board and agencies of America and Great Britain have united to build on the solid foundations laid by Dr. Scudder and her associates. Building of plant and increase of staff has been going forward energetically for the past five or six years.

Our Board joined in the undertaking, on the basis of its being the priority medical teaching center for the Christian forces in India. We felt that we could not do our share at Vellore, which still has extensive needs in plant and equipment, as well as staff, and at the same time single-handedly try to build Miraj up to the same college level. Hence the differentiation we have decided upon as between the two institutions: we want to back them both strongly.

To sum it all up: In this giant of young-old countries, with its enormous needs and multiform problems, we have highly strategic commitments and correspondingly strategic opportunities. We have great Christian contributions to make through hospitals and schools. Medical education and nursing education under Christian auspices are supremely important. The opportunities for a significant role in the remaking of India are beyond computation.

Only those who know India and the utter faith of the people in the healing powers of the sacred Ganges River can appreciate the following revolutionary statement:—

A Hindu, whose wife had just made a rather dramatic recovery at our Fatehgarh Hospital, stood up in the crowded reception room and announced:—"There is more healing in the dust of this place than in all the waters of the Ganges."

PAKISTAN

There is an unusual challenge to us in a new country like Pakistan. To be sure, there is much that carries over from the old inclusive India. After all, when a province like the Punjab is divided in two, life on either side does not halt or cease. But, as a political entity, Pakistan is new. The people think of themselves as something new, rather than as a continuation of something old. They are making a new start. The visitor feels this. Things are in the making. What will the formative influences be?

Our Board's deputation, consisting of Dr. Charles T. Leber, Dr. J. LeRoy Dodds, and Dr. Walter Clothier, felt all this when they visited Pakistan in the fall of 1948. There was a throb and lift to the life in Lahore. And they felt welcome. The new state needs all sorts of help, and realizes it. It has all sorts of critical problems. Sincere friends—Christian missionaries—can find their place in this emerging land.

Pakistan is a Moslem State. There is no question that Islam is the state religion. This was made clear from the start by the late Mr. Jinnah and his associates. With them Pakistan was essentially and vehemently a Moslem enterprise. The Moslems wanted to have their own country. They didn't want to live on as a disadvantaged minority in India. The agitation for separation, led by Mr. Jinnah and his followers, had more than a tinge of the old Moslem Holy War animus. And, as we know, when the split came, the mutual antipathy between Moslem and Hindu swept them all into the holocaust which took place.

That is past. With the setting up of separate states and the exchange of populations, the close-up friction and tensions are decreased, and both countries can go forward.

There cannot help but remain something of a question mark as to future attitudes in such a strongly Moslem state. Experience with predominantly Moslem countries in the past has shown a consistent pattern, varying, to be sure, in detail and intensity. In Pakistan there are evidently two schools of thought. There is the traditional, reactionary school, which is the orthodox pattern. And there is the new progressive, tolerant, co-operative pattern, which might be said to detour Islam. The latter attitude is what controls in Lahore, our chief point of contact, at present. And it behooves us to make the most of the friendly opportunity. We may have not a little to do with which school of thought eventually dominates.

Medically, Pakistan is in great need. The people are part and parcel of what we have seen medically in India. The professional class in the Punjab cities—doctors, nurses, teachers and what not—were predominantly Hindus. The faculty of the medical school in Lahore was largely Hindu. When the break came,

Pakistan lost practically all of these people. The medical school and the government hospital in Lahore face a difficult problem as to trained personnel.

The only medical work which we have had in this area has been the dispensary in Lahore so long carried on by Dr. Elsie Schuyler and her associates. Our hospitals in the Punjab fell on the other side of the line. Ferozepur is only a few miles from the border.

At this juncture, some Forman Christian College, Lahore, people, under the enthusiastic leadership of Mr. P. Carter Speers, made a great move. During the upheaval, when the college was drastically depleted of its largely Hindu student body and its splendid new buildings were lying idle, a relief hospital was set up in a group of its buildings at one end of the campus. The buildings lent themselves well to this purpose. This hospital was a joint enterprise among the Christian groups already at work in West Punjab. It did yeoman service and made a notable place for itself.

Different boards contributed personnel. Our Board sent out some short-term workers. Of these Dr. J. M. Harper, and Miss Esther Vail, R.N., were stationed at Lahore.

From this emergency start grew the idea of a permanent union hospital. It was a most intriguing and gripping idea. Instead of each of us going our small medical way, separately, here we have a chance to do something much better together. Here we are on the ground floor in the building of a newly evolving country, which needs us and wants us, where there is all sorts of formative opportunity. One of these special opportunities is in the field of nursing, in which Pakistan, with the handicap of the age-old Moslem inhibition on women's education, is particularly weak. If we can build a strong, specialized medical staff, they can probably teach in the government medical school as part-time faculty. And our well-housed hospital could be used as part of the clinical teaching base of the school.

So far our Board's share in this joint project now consists of:—

1. The college buildings, as the college plant is our property.
2. Personnel—Mr. P. Carter Speers, the dynamic promoter of the scheme, Miss Catherine Burnett, R.N., Mrs. Clarence Falk, R.N. (nee Miss Esther Vail), now a regular appointee.

The urgent need is for more personnel and more funds. This is the sort of opportunity which will not wait forever. The doors may close. We must move in quickly.

THAILAND (Siam)

Siam is again Thailand. The name is symbolic and meaningful. Thai means free. The country is again free to resume its preferred name and is free in its national life. The Japanese wartime occupation was unhappy and disillusioning, though not too physically destructive. The next national threat is Communism, which may sweep down from the North and attempt, in one way or another, to take over Thailand. Thailand is one of the few remaining bulwarks—along with the Philippines—in Southeast Asia. This little country will need all its strength and resources, built up on a long and honorable, independent, tradition. Thailand is one of the comparatively few countries of Asia, which has had a continuous, free and independent national existence for centuries. She has never been anyone's mandate, colony, or dependency. There is a lot of healthy psychology tied up with this fact.

Along with this, Thailand has a friendly tradition with our country. This has grown up over the years because of our fair and friendly diplomatic relations, and because of the American missionaries, who have done so much for the country educationally and medically. There is no anti-White-oppressor or anti-American feeling. So the foreign guest or friend—the missionary in this case—is accepted and appraised on his merits and not through a distorting cloud of resentment, as in some countries.

Buddhism is the dominant and all-pervading religion of Thailand. It is a complacent and comfortable, rather than a restive and fanatical, religion, like Mohammedanism. It has its pleasingly mellow and tolerant side, but also deplorable short-comings. There is no God. There is no satisfactory dynamic for a better ethic. Superstition rules much of the thinking. There is a sterile fatalism conditioning so much of life. Disease is looked upon as penalty and expiation for the sins of a former life.

One story from Buddhist Burma, next door, sharply silhouettes so much of the Buddhist attitude. Several years ago, Dr. Brayton Case, a missionary was in a railroad wreck. His car, the last in the train, was the only one which did not plunge through a broken bridge into a gorge. When he got out to see, he was confronted with a shambles. He sprang back into the car and cried for volunteers to help the victims of the accident. The car was full of good Buddhists. Not one moved to lend a hand. Only a young boy, who had been to a mission school, appeared. And they two went to work alone. The rest just sat back in their fatalistic, retributive theology of inertia.

This philosophy colors all too much of the people's attitude toward illness and health. If sickness is foreordained and justified punishment, why bother! This

Laying the corner stone of the Prince Mahidol Ward, at McCormick Hospital, Chiangmai, Thailand. Dr. Cort faces His Excellency the Governor of the province.



attitude has of course greatly changed, especially in the large centers, by contact with the West and through Christian medical work. But it still represents the controlling thinking of the vast majority of the population.

Dr. James W. McKean in his noteworthy pioneer work in leprosy found this to be very true in that connection. The patient with leprosy was a despised outcaste, who must have been a very bad person in a previous existence.

The supposed power of evil spirits is taken very seriously by the people. Charms and incantations are used to exorcise them. Epidemics of malaria are often attributed to local evil spirits. A malaria-ridden village may be moved,—not to escape mosquitoes—but to escape malign local spirits.

The Buddhist objection to taking life in any form carries into the insect world and is a serious obstacle to mosquito or rat extermination in a public health campaign against malaria or plague.

Among the diseases of Thailand, malaria is foremost. It is both acrippler and a killer. Amebiasis, hookworm, and typhoid fever are endemic and widely prevalent. Cholera and plague have, in the past, struck repeatedly with devastating epidemics, but are better controlled now by a western trained health department. Bladder stone is one of the common surgical conditions. Beri beri is a familiar condition. Leprosy has a considerable incidence. As with most of the Far East, tuberculosis is all too common.

Medical education in Thailand was begun by the government in a small way in Bangkok in the 1880's with simple instruction in "old and new medicine". The course was later somewhat improved. In 1921 the Rockefeller Foundation, on the invitation of the government, thoroughly reorganized and modernized the school. Young Siamese were sent abroad for study. And a well-trained faculty was built up. In the last years before the war, this institution was a strong school.



A representative ward building at the McCormick Hospital, Chiangmai, Thailand.

The war of course set things back. But they have been recovering lost ground since then. The graduates of this school have been the medical mainstay of Thailand. Most of them are absorbed by the government services or the large cities. The vast rural population is still largely uncared for.

Onto this rather friendly and very needy scene came medical missions only a century ago, when Dr. D. B. Bradley reached Bangkok by sailing ship (1834). Those were the primitive days, when travel was by river-boat or elephant. He was the first to introduce vaccination. But it was not till a half century later, when Dr. James W. McKean went out in 1889, that Christian medical work took solid root. He was a great pioneer. A small quiet, unobtrusive man, he was amazingly progressive, effective and creative. Long before medical schools in our country had courses in public health he was laying the foundation of public health in Siam, especially through smallpox vaccination. For years he organized and sent out a body of vaccinators who did remarkably effective work. The government later took this up with the result that Thailand has virtually eradicated smallpox. It has been called the best vaccinated country in Asia.

He went on to found the Chiangmai Hospital, which was later passed on to Dr. Cort, and developed into the McCormick Hospital, one of the best mission hospitals in the Far East.

Dr. McKean's greatest contribution was in the field of leprosy. Some fifty years ago, he began this work, later secured from the king the grant of a river island—which had been left to the vagaries of a sacred but destructive elephant—and there established a leper village, which has become a truly distinguished leprosarium. Not only has it been a mecca for medical men who study Leprosy but it has been a warmly evangelistic place, where nearly all the inhabitants become Christians. Moreover it has been a signal demonstration to all Thailand of Christian love in practical human form.

There was another creative accession to the Christian medical work in Thailand with the arrival in 1904 of Dr. Edwin C. Cort, fresh from Johns Hopkins. Those were still the days of pioneer medical work, jungle travel on elephants, and no trained Thai associates.

Among Dr. Cort's most colorful tales is that of lancing an abscess on the back of an elephant, where the "howda" had galled. For his "lancet" Dr. Cort lashed an old-fashioned razor to a bamboo stick. Then he ascended the elephant. With one deft incision he laid open the huge abscess. The he *descended* the elephant—*very* quickly! He claims that he holds the record for the rear-end exit from an elephant,—“in nothing flat”, says he!

Dr. and Mrs. Cort—for she has been an indefatigable help-mate, particularly with dietetics—have poured their lives into McCormick Hospital and its outreach.

It became not only the thronged focus of patients for a wide area of surrounding country, teeming with villages, but also a training center for Christian medical personnel—doctors, nurses and other workers.

For a time, before the modern development of the medical school in Bangkok, Dr. Cort and his associates gave an apprentice and practical course in medicine, which was officially recognized as a full medical education. On the basis of this course, Dr. Chinda Sinhanetra, who now heads the hospital since Dr. Cort's retirement, was admitted to postgraduate work at Johns Hopkins, where he was given a Master's degree in Public Health. This course at McCormick was discontinued when the Bangkok school came up to standard.

The nurses' training has been a strong feature of McCormick Hospital. This was developed over the years first by American nurses, such as Miss Agnes Barland, R.N.; Miss Sadie P. Lemmon, R.N.; Miss Helene Newman, R.N. and then by Thai nurses. The present head of this excellent school is Miss Civili Sinhanetra, whose brother has just been mentioned. She studied at the Rockefeller school and hospital in China, the Peking Union Medical College. Later she came to this country and has a bachelor degree and a Master's degree, from the University of Michigan.

Research at Mission Hospitals is handicapped by limited funds and staff. But the McCormick Hospital, Chienmai, Thailand, manages to do some research work.





These patients at the leprosy colony, Chienqmai, Thailand, are on their way to their church.

McCormick is now a modern hospital of some 130 beds, besides bassinets, with some ten or more substantial brick and reinforced concrete main buildings, and a medical staff of three Thai doctors and one American beside several interns from the medical school in Bangkok.

Though this account has featured two outstanding men, it would be quite unfair to leave the impression that there were not many others, who contributed largely and creatively, i.e. Dr. W. H. Beach; Dr. L. C. Bulkley; Dr. Douglas R. Collier; Dr. C. H. Crooks; Dr. J. V. Horst; Dr. W. Harding Kneedler; Dr. E. B. McDaniel; Dr. Nils Nedergaard; Dr. Henry R. O'Brien; and Dr. T. M. Proctor. At the height of medical work between the wars there were nine mission (Presbyterian) hospitals in Thailand,—extending all the way from the lower peninsula, south of Bangkok, to Chiengrai, north of Chiangmai near the China border. On a smaller scale than McCormick they made their telling contribution medically and religiously.

Our forward medical venture in Thailand is a new hospital in Bangkok. It has long been a question whether we should not have a strong Christian witness, in the form of a hospital, in this great capital and metropolis—with a population of over a million. This hospital is in embryo (1949). We have a fine, well-situated piece of property, with two or three serviceable but small buildings, in which a clinic has been started and a new building has been added.

The staff here consists of Dr. Marshall Welles, loaned from China, and Miss Ann Hoffman, R.N.

The most urgent material medical needs in Thailand are in connection with McCormick Hospital and the new Bangkok hospital.

Thailand is friendly, needy, in danger from Communism, open to Christian influence. Time runs out. The forces of darkness press in. Will we of the Christian Church be equal to the challenge?

PHILIPPINES

The "seven thousand emeralds"—those lovely emerald isles—of which Dr. Frank Laubach speaks, are still a peculiarly American concern. Aside from our own self-interest in the Pacific part of a world at tension, "the islands" look to us as to a Big Brother. We took them over from the despotic, stagnant, rule of Spain and Catholicism. We taught and led and developed—not wholly without mingled self-interest—until they learned the ways of democracy and health and progress. Then, after the catastrophic Japanese occupation, and the devastating war of liberation, they were set on their feet as a full-statured, free and independent nation in 1946. They have a very hard job on their hands. Not only would they have a hard enough job of starting on their own, but they have the frightful material and manpower and morale devastation of war. Manila is said to be the worst destroyed city in Asia. It was a shambles. Both the people generally and the Protestant Christian Church suffered terribly.

The country and the Christian Church are rising out of this with vigor and hope and determination. They are doing a fine job. We should help all we can.

Religiously, the dominant background was Spanish-Catholic. This had certain cultural assets but also made for bigotry, ignorance, and violent opposition to Protestant Christianity. The religious "climate" is now much more free.

Some years ago the writer was told an interesting story by the late Dr. Graham on one of the outlying islands. It seems that a visiting Catholic priest was preaching, and his sermon was chiefly a vituperative attack on Protestants. "This island," he said, "is cursed with one of the most pernicious forms of Protestantism—the Presbyterians! And, worse still, where the Presbyterians once take hold they never let go!"

The delightful sequel to the story was that the servant who reported this diatribe to Dr. Graham, inquired, "Who are these Presbyterians of whom the Father spoke?" Dr. Graham, mind you, was a Presbyterian missionary under the Presbyterian Board. But the work was so undenominationally-minded that the servant didn't even know that his local Protestant church was so connected.

Medically, the Philippines, since the backward days of Spain, have ranged from primitive communities, infested with tropical disease and with few, though growing, medical facilities, to the highly developed city of Manila, with good hospitals, two medical schools, and a scientifically trained medical profession.

The United States regime did great things in public health. Smallpox was all but stamped out. Cholera and plague was kept out. Children had a better chance to grow up. The whole thinking of the people was advanced considerably in ways of health and medical care.

The University of the Philippines developed a Grade A medical school—the only high-grade medical school in the country.

The four war years were a tragic set-back. Even where there was no bombardment, as there was in Manila, there was a terrible falling off in doctors and drugs and hospitals, coupled with poor food and shelter and great exposure to all forms of disease. Nearly a million people in Manila were homeless and destitute. Malaria, which had been coming under control, ran rampant again, as in the days of Spain. Dysentery, typhoid, cholera and tuberculosis claimed thousands of lives. It was said at one time, after the war, that half the population were so anemic and depleted that they couldn't work.

At the end of the war the American government, the Red Cross and the Christian Missions took hold. The Army Medical Corps organized and sent out eighteen anti-malarial units, and supplied other services and supplies. The Red Cross sent out teams to give emergency relief including quantities of vitamins, and to teach health measures. Church World Service, the relief arm of United Protestantism, sent out clothing, food, vitamins, and drugs. The returning missionaries with their Filipino colleagues, went to work on the rehabilitation of churches, schools and hospitals. Our own Restoration Fund helped, and is helping, greatly.

The National Government has an intelligent, vigorous, medical program, but is severely handicapped by the low state of the exchequer and the paucity of doctors, nurses, and hospitals. It welcomes our help. When medical representatives of our Board visited the Philippines in 1946, the Director of the Public Health Institute in Manila went out of his way to express appreciation for what Christian Missions had done and were doing, and to urge that more such medical help be extended. Again, when Dr. Paul S. Rhoads visited Manila in 1949, in behalf of the Board, he found a most co-operative medical atmosphere.

In response to this we, the great Presbyterian Church in the U. S. A. have sent exactly one (full-time) nurse since V-J Day. One doctor, after recovering from the effects of the Japanese internment camp, was available to return from furlough. These two are our only foreign medical force in the Philippines!

Before the war the Presbyterian Church, through its Board of Foreign Missions, maintained four hospitals in four different islands.

In the north on Luzon, down on the Legaspi peninsula, was the hospital at Albay, with Dr. W. W. McAnlis in charge. This hospital was completely destroyed in the war. But Dr. Fontanilla, the Filipino second in command, salvaged a considerable part of the equipment by removing it to a near-by village. There in the wilds, the refugee doctor and his helpers cared for very needy patients and were paid in chickens, eggs, bananas and what not.

This hospital has continued in this town and by mutual arrangement is now a private Christian hospital in the able hands of Dr. Fontanilla.

Farther south was the hospital at Tagbilaran on the island of Bohol, of which Dr. J. A. Graham and his fine associate Dr. Pio C. Castro were in charge. After Dr. Graham's death, Dr. Castro continued the work until the war came. Then the hospital did a rapid dismantling act. Christian Filipinos trekked off into the

hills with the equipment and supplies, which were hidden for the duration in scattered hamlets and caves and where-not. At the close of hostilities everything was brought back, and the hospital under Dr. Castro resumed.

At Tacloban, on the island of Leyte, Dr. J. Andrew Hall, carried on another active and warmly evangelistic hospital. After Dr. Hall's retirement, before the war, Dr. Dolorico his trusted associate, carried on. The hectic war story was repeated here.

Down in Dumaguete, the hospital, which is located on the campus of famous Silliman University, has had another interesting career. Dr. George Cunningham and Miss Alice Fullerton, R.N., were the constructive geniuses of this attractive and busy little hospital in the years between the wars. The program included a nurses' training school. When Dr. Cunningham retired from the work there was again a high-grade Filipino lieutenant to take over—Dr. Jose Garcia. Many of us learned to know and love him when he came to this country for postgraduate study a number of years ago. When the war broke he elected to go to the hills and help with the resistance movement, in which he was a heroic leader. When the Japanese occupation ended he came back to Dumaguete and is in charge. With him has been a strong Filipino staff and Miss Mary Marquis, R.N.

All four hospitals, then, are functioning. And they have reached that desired stage of missionary policy of being run by capable nationals and in relation to the National Church of Christ.

Now we are reaching out to start a new hospital. This will be at the city of Cebu, on the island of Cebu. Cebu is the second city to Manila. There is no Christian hospital there. Restoration Fund money will be the main reliance in building this hospital together with contributions from the Filipino Church and community. Dr. W. A. McAnlis will be in charge.

As we look ahead, we see pressing medical needs in the Christian program:—

1. The health conditions of the islands, though gallantly recovering, are very hard hit. Far more is needed in the way of hospitals, traveling clinics, and preventive medicine. The few mission and church hospitals can meet only a small fraction of the need. They must be strengthened.

2. Nursing education should be pushed. The supply of trained nurses is woefully short. The Filipino young women respond splendidly to this program and make excellent nurses. Our school at Dumaguete needs equipment of all sorts.

3. One of the greatest needs is a Christian medical school. At present the total supply of doctors is far below the needs. And Protestant students are at a sharp disadvantage in securing admission to the Catholic-dominated medical schools in Manila—the only medical schools there are. Very few get in.

This is a matter which is receiving considerable thought. It is to be devoutly hoped that some day the Christian forces will be able to finance and staff a medical school. A medical school is not a project to be undertaken lightly. But it is too challenging, essential, and rewarding an undertaking to rest there indefinitely.

CHINA

Perspective

China is a huge question mark. And China is a searching challenge. Neither the question nor the challenge are entirely new, for China is a country with a long past—a meaningful past, a past with vicissitudes and uneven progress. Of all countries, China has to be thought of in perspective.

Right now, in the fall of 1949, our attention is concentrated on the Communistic sweep through China. To some people it looks like sheer catastrophe, not only for China but for all Asia, and to others like a shining new hope, to others as a confused turmoil with no clear direction. Most certainly Communism is of great import in China, for weal or woe, or a prolonged indeterminate period of *something*. It is the most powerful and important single factor, which bears on our Christian work, in the immediate scene. But, before going into this further, let us go back in the story, let us get the history of the patient, and see what a bit of perspective can do for us.

The last fifty years

These last fifty years have been characterized by a succession of more or less violent social and political upheavals and sweeping changes. They have been a revolutionary period. The Communists identify themselves as the culmination and cap-stone of the revolution.

Fifty years ago the violent, anti-foreign Boxer uprising broke the calm of China and Europe. Some foreigners were killed. The whole body of missionaries had to flee the country. The outlook for Christian work looked dark. Many people thought it was doomed. But within a year or two there was a complete comeback of foreigners including missionaries, and Christian Missions took on new momentum. The country began its long march into the modern era.

In 1911 came the idealistic internal revolution, led by Dr. Sun Yat-San, one of the remarkable men of history. The Manchu dynasty was abolished. The republic was founded, at least in theory. There ensued a chaotic period of inadequate control from headquarters and with local war-lords running things till the middle of the 1920's. To some extent even this was a repetition of Chinese history.

In 1927 the new Kuomintang party, with Generalissimo Chiang Kai-Shek as its military spearhead, swept up from Canton in the South. There was strong Communist influence in the picture then. And Russian agitators and propagandists were conspicuous. The culmination of the military phase of the revolution then came with the fall of Nanking. This included violence toward foreigners and their dramatic wholesale evacuation to foreign gun-boats in the river. Dr. John E. Williams, one of our great Presbyterian missionaries, vice-president of Nanking

University, was killed by a casual soldier. His death was a shock which had a salutary effect on the Chinese leadership, already dividing between the moderates and the extremists. Presently the Kuomintang and Chiang broke with the Communists and expelled them—thereby starting the long feud.

For a time it was again a dark hour for Christian Missions. Almost all missionaries evacuated and the work was severely interrupted. Anti-foreign feeling ran high.

Gradually the age-long moderation and reasonableness of the Chinese resumed control. Foreigners returned to all parts of China. Missionaries went back to their work. The Kuomintang started a nation-wide progressive program, based on the ideas of Sun Yat Sen, who had died. Education in particular forged ahead most encouragingly. Roads and railroads were built. Cities were made over. A national health program, with a strong official headquarters in Nanking, the new capital, was inaugurated. Mission work went forward to its period of greatest success.

The Great Decade

The decade from 1927 to 1937, when the Japanese struck, was a notable decade in Chinese history. It showed what China could do.

War and aftermath

Then came war. And everything went backward. China fought for her life. We in America, comfortable, at peace and remote, anxiously followed the news month by month, and then year by year, as the National Government under the gallant leadership of the Generalissimo, retreated step by step into West China. The trek of colleges and schools—particularly of the Christian colleges—into the far west country is an epic. Missionaries again left in large numbers, or elected, as so many of our people did, to stay and take it. They were interned by the Japanese and, after internment were repatriated on the famous *Gripsholm*. Again it looked like eclipse for Christian missions.

From the eight years of war China emerged a wreck. Governmental functioning had deteriorated badly. The economic conditions were terrible. Inflation ran to fantastic heights. The Chinese dollar, which used to be about 50¢ to our dollar, ran into millions for our dollar and changed every day—always getting worse. The people were disillusioned as to their corrupt and inefficient government. They were utterly discouraged and fed up so that any change looked good to them. This was where Communism, with its bright promises, had its chance.

In the meanwhile, between V-J Day 1945 and 1949, Christian Missions took hold again and advanced. Our medical work, hard hit by the war, was resumed as vigorously as possible. We could not re-staff all our hospitals. But several of them had survived in the gallant hands of Chinese doctors and nurses. In the fall of 1946 the Board sent out a deputation to re-study our work and make long-range plans.



Nurses from Hackett Medical Center, giving first aid to refugees.

The moral

This very sketchy outline of the last fifty years is enough to suggest caution against pessimism. If the sky seems overcast now, the sun is still there and may presently break through, as it has done so frequently and hearteningly in the past. If the Christian Church had given up in 1900, in 1911, or 1927, or 1937, there might be little or nothing to build on now. Instead of that, the Christian Church has accepted each crisis as a challenge and has gone from strength to strength, till now there is a substantial Church of Christ from north to south and east to west.

Parenthetically, let it be pointed out here that we are not building a *Presbyterian* church in China. It is a united Church, in which we have a part. It is known as the Church of Christ in China, just as in India and elsewhere.

To be sure, one may say, "But this time it is different. This is something new. We haven't had Communism before." There may be a point there. But Chinese history, especially the history of the Church, is on the side of the angels. He who fears that the Christian cause in China is doomed has to shoulder the burden of proof. Hitherto at least, every ebb of the tide has disclosed sturdier underpinnings that endured, and every flow has risen higher than before. In all our fields of endeavor there is no field which has had such upsetting vicissitudes, but no field which, taken in the large, has been more rewarding than this extraordinary land of China.

There comes back to me at this moment a remark made to my cousin, Tom Carter, formerly a missionary in China, by a mellow old Chinese scholar when I was in Nanchow many years ago. They were discussing Russia and Communism—then only a distant rumble, as far as China was concerned. Said the Chinese gentleman—"We tried that (i.e., Communism) way back in such and

such a period (hundreds of years ago), and found it unsatisfactory and gave it up!" The Chinese may again change and mold or reject the innovators as they have done so often in the past.

Medical history

What of the medical history, which gives us its distinctive perspective of life and work in China?

Old China had an elaborately developed system of medicine. Dr. Edward H. Hume, to whom we owe so much in the medical story of China, tells of a conversation he overheard one day in a restaurant in China. A group of modern trained Chinese doctors were discussing old Chinese medicine and Western medicine. The trend of the discussion was that modern surgery clearly carried the palm, but that in medicine, as distinguished from surgery, the old Chinese medicine still had much to offer and should be included.

As Dr. Hume brings out in his writings, the old Chinese medical system, by century-old trial and error, had hit upon some valuable truths. For example, in cretinism, which is essentially a glandular and particularly thyroid deficiency disease, the old Chinese doctors used to feed the patient sheep's thyroid. They had stumbled on something. Ephedrine was used long ago in China. Centuries ago the mayor of Changsha—a scholarly individual—gave an excellent description of how to give tub baths to typhoid fever patients. In the days when we still had typhoid in this country "tubbing your typhoids" was part of the accepted treatment. The Chinese did this long before we did.

The tale has been told more than once of the famous Dr. Manson—later Sir Patrick Manson—the "father of tropical medicine." When he was a young man in South China a foreign patient came to him for treatment of her sprue. Sprue was, and is, a serious wasting disease, for which there was then no known effective treatment in Western medicine. When Dr. Manson's best was ineffective, the woman resorted to an old Chinese doctor. He put her on a regime of liver soup and she recovered. One day she greeted Dr. Manson on the street and twitted him with the experience. We know now that sprue is a vitamin deficiency disease and that liver extract is the best answer.

When all is said and done, however, and due credit is given to the old medicine of China, it left an enormous lot to be desired. In a crude, empirical way, and accompanied by shrewd psychology, it filled in some needs here and there but the gaps between were chasms in comparison. The epidemic masters of death—cholera, plague, typhus, typhoid—ran rampant when they pleased. As a Chinese doctor said to me last year, when the Communists were advancing on Nanking, "There is (was) nothing to stop them." Endemic diseases such as hookworm, kalaazar, beri beri, the dysenteries, malaria, were accepted fatalistically and took their heavy toll year in and year out.

When the devastating recurrent floods came from one of the lawless rivers of China and tens of thousands of people were homeless and destitute and dying,

there was no such thing as a public health program to protect them and others—under the old order. Now there would be but a generation ago the Government had no answer to such onslaughts. And still less did the old style Chinese doctor have any idea of what to do, or that anything should be done.

Advance

Within the last twenty years the general medical picture has changed greatly—for the better. Great advances have been made. If only the progress of the decade 1927-1937, could have been maintained—it probably would have been *accelerated* instead of being terribly set back by the war—China would now be well on the way to an adequate medical set-up. But before we come to the present picture, we should review briefly the story of medical missions.

Medical pioneering

Dr. Peter Parker, who began work in 1837 in Canton, is generally considered the pioneer medical missionary of China. His special contribution seems to have been in eye work—particularly cataracts. It was said of him that he “opened China at the point of a lancet.”

For the next half century or more his colleagues or successors were not numerous. It was not till about the turn of the century that medical missions in China really began to gather momentum. The abiding and significant work has largely been within the last fifty years—just the years of greatest upheaval and hazard.

In our Presbyterian family connection some of the names which stand out in these foundation-laying years are Dr. O. T. Logan, who did so much for the cause in Hunan; Dr. Charles Lewis, the justly famed and beloved “Loo-Dai-Foo” of Paoting-fu and his brother and sister, Dr. Stephen Lewis and Dr. Elizabeth Lewis; Dr. James Neil, one of the founders and later dean of Cheeloo Medical School; Dr. Elizabeth Leonard, head of the former Woman’s Medical School in Peking, which amalgamated with Cheeloo; Dr. Samuel Cochran, already mentioned, of Hwai Yuan and later dean at Cheeloo; Dr. Charles Dilley, surgeon and leading citizen of Cheefoo; Dr. John G. Kerr, who started the first, and for many years the only, psychiatric hospital in China at Canton; and Dr. Martha Hackett, whose name endures with our Hackett Medical Center at Canton our great pride and joy.

Apropos of the place these men and women had in their communities, the writer remembers landing alone one day at the railroad station in Paoting-fu, destined for a visit to Dr. Charles Lewis’ hospital. The Chinese telegraph system had failed me. And here I was dumped alone into a strange city, fairly swamped by a madly shouting barrage of rickshaw coolies, with no language and no identification. Fortunately I had been given the open sesame. When I had struggled through to a ricksha man, chosen at random, all I needed to say in my smooth Mandarin, was “Loo-Dai-Foo.” He grinned and nodded enthusiastically and shot off into the blue—after the delightful manner of Chinese ricksha men. In a little while we were at the hospital gate.

World War II has brought to Medical Missionaries around the world, many a refugee situation like this in Shanghai, China.



All mission work was slow work in those pioneering days, fifty years ago—medical work included. Patients did not immediately throng to the embryo clinics and hospitals, as they throng now. Foreigners were still foreign devils, and foreign medicine was something alien and forbidding. It took patient, kindly, loving, skilled care—*years* of it—to gain the confidence of the people: a strangulated hernia snatched from death here, a malaria case relieved there, a desperate maternity case salvaged, a child with diphtheria incubated to life from the choking brink. Little by little, the people learned and came and trusted. In the end they recognized a certain something distinctive about a mission hospital—a spirit—so much so that not infrequently they would ask, “Is this a Christian hospital? Are there Christian doctors here?” before they would entrust themselves or their dear ones.

Functional pioneering

Along with this geographical pioneering, by which village after village, city after city, province after province, was gradually opened to the beneficent services of Christian hospitals and to the Christian message, there went some most significant pioneering in areas of life. Among these are the long-range contributions which we now emphasize.

Medical education

The statesmanship of the leading pioneers of forty or fifty years ago was nowhere better exemplified than in early concern for medical education under Christian auspices. They considered this to be the strategic long-range program. China must have well-trained Christian doctors. The foreign doctor was not enough and never could be enough. It was very undesirable that he should *try* to be enough. He must multiply himself by nationals. So they went to work here and there.

Those early efforts at medical schools were small and scattered individualistic efforts at first. Then, as the doctors got together in the growing and highly useful Christian Medical Association of China, and more and more thought together,



Graduating class of School of Nursing, Hackett Medical Center, Canton, China.

they joined hands and consolidated medical schools. By the middle of the 1920's the medical education program had crystallized out into six Christian medical schools—at Mukden, in Manchuria, at Tsinan-fu (Cheeloo), at Chengtu (West China Union University), at Shanghai (St. John's and the Woman's Union Medical College), and at Canton (Hackett). Four of these six were union institutions, in which a number of denominations co-operated.

We were associated with two—Cheeloo and Hackett—the former a union institution and the latter solely a Presbyterian responsibility. We can be very proud of both of these splendid institutions.

This was the picture when the war with Japan broke in 1937. Cheeloo medical school trekked hundreds of miles by one means and another to West China where it was given a hospitable, temporary home with West China Medical School at Chengtu and carried on gallantly. It was as though Chicago University walked and thumbed and railroaded itself across the plains and deep into the Rocky Mountains and camped at Salt Lake City. Hackett Medical School, which was already affiliated with Lingnan University and the Canton Hospital, founded by Dr. Peter Parker, went out of existence as a separate medical school entity, but Hackett continued as a strong hospital and teaching center—of which more anon.

Nursing education

Hand in hand with medical education went nursing education. Training schools were developed at the hospitals far and wide. This was perhaps a greater innovation than the training of doctors. Nursing, as a skilled, high-class profession was something entirely new—as we have already seen in other Asiatic countries. But it took root and grew thrivingly.

The present day well developed, splendidly led Chinese nursing association is the direct product of medical missions and of pioneering American nurses, who had the vision. Those of us who were privileged to meet some of the leading Chinese nurses, when they came on for the International Congress of Nurses held at Atlantic City in 1947 were deeply impressed by them.

Public Health

The name of Dr. W. W. Peter and the Council on Public Health Education, in which we had a small part, will always stand for pioneering in this significant field. It is a pity that space fails to give that story. Suffice it to say that much of the progress in Public Health in the great decade has been attributed to the ideas, the stimulus and the trained people emanating from the Council on Public Health and the dynamic personality of Bill Peter.

Our hospitals

When the war broke out our Board and Missions had 25 hospitals in China, not counting the union hospitals of Cheeloo University and Nanking University, as follows: from north to south,

North China	3
Shantung	6
Kiangnan	4
Central China	2
Hunan	4
South China	3
Hainan	3

25

These hospitals were each staffed by one or two American doctors and usually one American nurse as well as several Chinese doctors in most cases. They were practising good modern medicine within the cramping limits of their small staffs and inadequate funds. They were largely self-supporting—upwards of 90%—as far as current expenses went—apart from the salaries of the foreign doctors and nurses. This to be sure is a prevailing situation among our hospitals, which is certainly not the ideal setup. More of this later.

Tribute

I wish it were possible to give an adequate picture of what these 25 hospitals meant in the cause of the Kingdom. They were a living demonstration of the

The new hospital at Hackett Medical Center, Canton, China, almost miraculously escaped during the bombing of that city and rendered incalculable service to the victims of the bombing.



Christ-like ministry of healing. Anyone who has been in the children's ward of the Cragin Memorial Hospital, Hwaiyuan—to choose just one—in the days of Dr. Agnes Murdock and Miss Margaret Murdock, R. N., will know what we mean. The happy children, the smiling grateful parents, the general air of good work being done in an atmosphere of loving care and good cheer, left an indelible memory.

I wish it were possible to bring together the impressions and statements in regard to the Hackett Medical Center by highly competent objective medical observers who were there during or just after the war. They accorded it high praise.

Much of the recent splendid work of Hackett is due to Dr. Ross Wong. It was Dr. Wong who carried on through the Japanese occupation with such courage and efficiency and distinction when the Americans were removed. When the Japanese first came in Dr. Wong was deposed as Director and a "puppet" staff was put in. They were utterly incompetent. It was promptly evident that this much-needed hospital would be a total loss. So the Japanese recalled Dr. Wong and asked him to take charge again. He did so, on condition that he was definitely in charge with his own staff and that the Christian name of the hospital went up over the gate again. So highly was he respected by the Japanese that it is said that the high-up Japanese officers used to salute him on the streets—which in those days, let it be said, was *something*.

The whole record of Christian Chinese doctors and nurses during the war was a magnificent one. Time and again they remained at their posts under most trying and often very dangerous conditions, and pulled things through. The *sharing* of danger, by the way, by Chinese and foreign staffs, when they could all have escaped to relative safety, was one of the wonderful experiences and demonstrations of the war period.

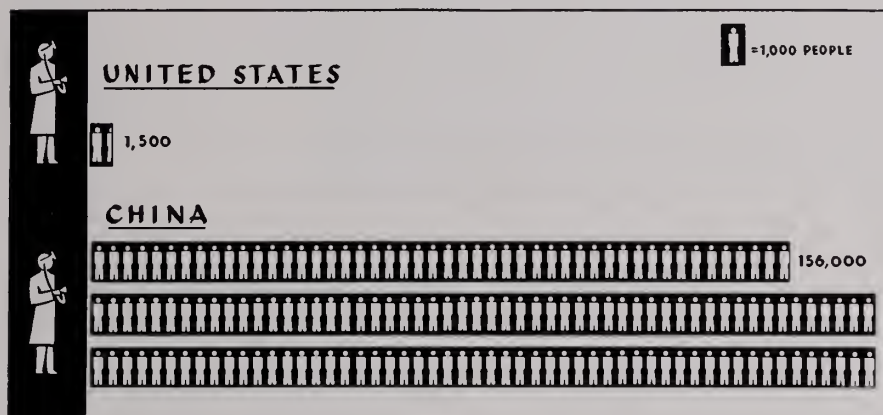
No finer tribute has been paid to medical missions in China than by Dr. P. Z. King, while head of the National Health Administration in 1944:

"It is a well known fact that the concepts, teachings and practice of modern medicine were first brought to China a little over a century ago by medical missionaries; that modern education, including medical education, in China owes its start and a great deal of its impetus even to the present day to schools, colleges and universities started and maintained by Christian agencies.

"At this time it is only fitting that warmest thanks and highest tribute be paid to the Christian medical services—in all forms—for the fundamentally important part they have played and continue to play in the development of modern medical practice in China. It is earnestly hoped that these services will not only be continued but extended. In the past they have played a leading part in the maintenance of health facilities and in the training of medical personnel of high quality; as the government training programme develops it is earnestly hoped that the Christian medical colleges will continue to maintain and even to improve the standard of training and at the same time to increase facilities so that even larger numbers of well-qualified personnel may become available. Without

the fullest possible co-operation and extension of the Christian medical services that achievement of the nation's hopes and plans for a comprehensive health service will be very difficult, if not impossible, for a long time to come."

The general medical picture, postwar



According to Dr. S. Sze, General Secretary of the Chinese Medical Association and Editor of the Chinese Medical Journal, writing in 1944, China had 12,000 modern trained doctors, whereas, on the basis of one doctor to 1500 population (U. S. suggested standard), she should have had 266,000 doctors. Or to put it differently, China has approximately one doctor to 156,000 people. As to hospital beds, there were in all China 38,000 beds—less than in New York City—whereas the figure should be around 2,000,000. But the picture is worse than these figures indicate, as Dr. Sze points out, because China, with perhaps twice the incidence of disease, should have twice that ratio of beds. Moreover, the distribution of these doctors and these hospitals, as has been noted in India, is uneven. "Practically all hospitals and doctors are concentrated in the large cities, leaving the rural areas, where 84% of the population lives, virtually without modern medical facilities.

At the same time, China had been making notable progress. When our Board's deputation was in China in 1946, they were much impressed with what was being accomplished by the Chinese themselves in large centers, such as Nanking, the capital. The Chinese Government teaching hospital there far outdistanced our fine Nanking University Hospital and our other hospitals in size, equipment, number and specializations of staff. This is the story in many large centers of Asia. Great progress is being made in hospitals. In these places our hospitals hold their own for the present, on *character*, rather than superiority of plant or equipment or x-rays or laboratories. This is said for large *cities*—not for the towns and villages, which last are the great bulk of China.

A special tribute should here be paid to what the Restoration Fund meant in the rehabilitating of our hospitals after the war. It was veritably life-giving.



These substantial buildings are the hospital of Cheeloo University Medical School in Shantung province, China.

When our Board's deputation went to China in 1946, besides visiting the various hospitals, it held a medical conference in Shanghai. This was the first of its kind, in that it brought into consultation a cross section of our medical force and thought out medical policies as a whole, both as a Presbyterian program and integrating co-operatively with other denominations and with the government's medical program.

In addition to Dr. W. J. Barnes of the deputation, the following were chosen as representatives of the medical force:

Dr. N. Bercovitz	Dr. Frederick G. Scovel
Dr. Williams Cochran	Dr. George T. Tootell
Dr. J. Horton Daniels	Dr. Ross Wang
Dr. E. E. Murrar	Miss Rena Westra, R.N.

This conference, among other things, restated the "determining purpose of our work," as follows:

1. To demonstrate Christ's life in action in service to the community, and thus to lead others in complete Christian living, into being "Christian-minded."
2. To comfort sick and injured persons, to relieve suffering, to cure the diseased, to prevent the development and spread of disease, to promote complete and vigorous health.
3. To set a high standard of medical science, in medical practice, in medical and nursing education.

The report of the deputation has been our charter for our medical program in China—now partially interrupted by the political change.

Among other things, the report advocated concentrating our strength on six selected centers from north to south, including the two leading teaching centers of Cheeloo and Hackett, and organizing the other hospitals as affiliated simpler institutions in close relationship to the central hospital for each area.

This plan has been most nearly realized thus far at Siangtan, under the able leadership of Dr. Frank Newman. Siangtan was selected as the center for Hunan province. In this instance the plan has been to remodel two good unused school

buildings as the new hospital. This had been largely completed before the city was occupied by the Communists, in the late summer of 1949.

One of the best things which the deputation did for the work in China was to recommend to the Board that there be a medical person on the three-person executive group of the China Council, in Shanghai, to supervise and co-ordinate the whole medical work. The Board passed this action and Dr. Everett E. Murray, of Weihsien, Shantung, was elected to this position by the China medical group. The general idea of such a position, and the selection of Dr. Murray have been admirably justified. It has resulted in a far more unified over-all strategy for the medical work of our Board and missions in China than ever before.

Our hospitals in China are now (fall of 1949) behind the "Bamboo Curtain," except three on the island of Hainan. So far the evolving situation, which admittedly is too early for final appraisal, is more encouraging than was feared. Most of the hospitals which were open when the Communists came in are still in operation. So far they are carrying on unmolested. Two doctors who had moved to Canton, Dr. Cochran and Lewis, and their families, have been permitted to return to Peking, in Communist territory.

Here and there we get a glimmer of that for which we hope and pray—that the Communists may see the true worth of Christian medical work as they come in actual contact with it, and that this work may make its impress on them.

A Communist soldier, who had been a patient at Douw Hospital and who was later a patient at a Communist hospital, wrote back to Douw Hospital very appreciatively over the kindly and efficient care received there and added that he wanted to hear more about Christianity of which he had first heard in the hospital. He went on to say that Communism and Christianity were very much alike in some ways and very different in others.

As already noted, it is the boast of the Communists that they are the only ones who care for the common man. They find, as they come down through China, scores of hospitals which for the past forty or fifty years have been caring



Well treated and early treated leprosy can respond, as these "before and after" pictures show—from Dr. Stuart P. Seaton, Hainan, China.





One of our largest and most active hospitals is in the Island of Hainan, China. This was the staff gathering for a birthday party for Dr. Bercovitz.

effectively for the common man and not only taking care of his existing ills but helping him to prevent them in the future. They cannot all together ignore or obliterate the regard of the common people for these hospitals. Who knows what this "teaching function" of these hospitals may prove to be.

One cannot now give a clear forecast of our work in China. We are moving through an evolving revolution, the full shape of which is yet to appear. Conditions of work are bound to be very different than in the past. There will be many and difficult problems. They will call for all of our faith and patience and tact and wisdom and resourcefulness and prayer.

Of one thing we are convinced. We must stay by and carry on as long as possible and wherever possible. We believe that the Christ-like ministry of healing has its distinctive part to play. About one hundred of our missionaries are staying behind the Bamboo Curtain. They need our utmost backing.

The spirit of our medical force in China is well expressed in a letter from Dr. Frank Newman:—

To the question whether they should leave he replies: "The answer is definitely 'No'. The time is now. There may not be—almost certainty cannot be—any second chance if this fails. If the hospital does not maintain high standards, it may be summarily closed and the buildings and equipment confiscated. This has happened elsewhere and we pray it may not happen here. We are under constant observation and nothing can be concealed. This is our one chance.

"God has surely called us to be here at this time. Our churches have been his instruments for sending us and maintaining our work thus far. He has wonderfully kept this little outpost, protecting it against the forces of darkness. We can hardly believe that he means for us to surrender now just when the real test comes. Church history is not like that. In some way, and it will almost certainly have to be a miraculous way, the men, the money and the transport must be found to keep this work going in the way that a Christian hospital ought to go."

KOREA

"Whom the Lord loveth he chasteneth." On this basis the Koreans must be greatly loved. They have had more than their share of troubles in the last forty years. From 1910, when Japan *took* the country, to the close of the second World War, Korea was a dependency of the Japanese Empire, wholly against the wishes of the Korean people. Japan brought in much material progress. But it was an alien, autocratic, harsh rule. The Koreans resented it bitterly but were helpless. Uprisings were put down with brutal force and imprisonment and torture were all too common experiences of the unhappy people.

When V-J day burst upon the Far East, the Koreans were jubilant. The day of liberation, for which they had hoped and prayed and waited in sweat, blood and tears was at hand. But their hopes were again thwarted and threatened when the Russians occupied and closed off the whole northern half of the country. The all too familiar Iron Curtain went down, at the 38th parallel, and cut the nation into two utterly disjointed parts. Temporarily the southern half was placed under United States Army control, while the new Korean government was being organized. The United States troops were withdrawn in the summer of 1949. And the newborn Korean administration was left to face its problems,—the most ominous of which was the Communist threat from the north.

One of the problems all along has been the constant influx of people fleeing from the north. Whenever they can, people escape over the hills and across the line, at risk of life and limb, and become homeless refugees in the south. The total (1949) has topped two million. These people report that the Russian rule is much worse than the Japanese.

Our consideration of Korea, for present practical purposes, must of necessity confine itself to the south. The north has to be left out of immediate reckonings, —though not out of our hopes and prayers.

Korea, as we go back over her history, has been predominantly an agricultural country. (Korea, by the way, has a population of about 30,000,000, with 20,000,000 south of the 38th parallel, and is about the size of Minnesota.) Along with their rootage in the soil, the Koreans have consistently handed down a love of learning. It has been said that the "*summum bonum*" of every Korean was to read and study. Centuries ago they devised a logical script and a printing press with movable type. Their scholars and philosophers devoted themselves to "the love of wisdom". The village folk evolved a thoughtful, homely philosophy of life.

Confucianism has been the main religion of the country, though spirit worship, especially in the form of ancestor worship, has mingled with it. As with so many peoples in Asia, we get a mixture of religious thought and practice,—the

ethnic religion or religious overlying, but not wholly obliterating the older animism.

Christianity has made striking progress in Korea. The greatest response to missions of our connection have been in Korea and Africa. The first President of the country, Syngman Rhee, is a Christian. So are many leaders in different walks of life,—out of all proportion to their numerical ratio. The Christian Church in Korea is heroic and devoted and growing.

The diseases of Korea correspond about as much to those of our temperate zone as they do to the tropical part of the world. Smallpox used to ravage the land. As recently as 1921, there were 2,500 deaths reported from it. The Japanese government made great efforts at vaccination. And, as a result, the incidence of smallpox was markedly reduced. Typhoid has always been present. Dysentery, both amebic and bacillary, are common. Amebic abscess is a frequent complication of the former. Dr. A. I. Ludlow, F.A.C.S., when chief of the surgical staff of the Severance Union Medical College in Seoul, operated and wrote up one of the largest series of cases of this on record, and was recognized as an authority. Cholera epidemics used to sweep the country. The last severe one seems to have been in 1920, with 13,000 deaths. Cholera is now a minor threat. The contagious children's diseases run rampant. Hookworm and other parasites and malaria are all too prevalent and do much health damage. And so, too, with tuberculosis. Leprosy, found chiefly in the South, rates as a public health problem. Venereal disease has greatly increased of late years.

Old style Korean medicine, though containing a few worthwhile things, as in China, does not have much to offer. When the first missionaries arrived in 1884 they found the Koreans practicing acupuncture with needles and making medicine from deers' horns, bears' gall bladder and centipedes. Such ideas and practices still linger in the countryside.

The Japanese, let it be said, did considerable, in their way towards better medical facilities. They established eight medical schools and a number of well-staffed city hospitals. They introduced some public health measures. The value of much that they did with one hand was lost by what they did with the other. Crudely and roughly administered health measures did not tend to win popular support.

At best, there was still a wide gap between medical need and medical facilities. Dr. A. A. Fletcher, speaking of conditions as he knew them in Korea, pre-war, says that perhaps one out of fifty of the people who needed it, were treated in a hospital. Medical facilities deteriorated badly during the war. So the gap is even worse now. Moreover, as in so much of Asia, the low economic level of the people makes it impossible for most to pay for modern medical care.

Again, here is where we come in.

The keystone of the Medical Missions Program in Korea was, and again, we hope, will be Severance Union Medical College at Seoul. This splendid institution, founded some fifty years ago by Dr. O. R. Avison, was the united under-

taking of nearly all the main Mission boards working in Korea. The hospital, the medical school, and the nurses training school served as a medical center for everybody. Its graduates were recognized by the high standards of the Japanese Government and they were the mainstay for the Mission Hospitals throughout the country.

When Dr. Avison, a promising young physician in Toronto, Canada, first decided to go to Korea his friends and colleagues tried to dissuade him. "What can you hope to do with all those millions of sick people in Korea?" said one, "You are a fool to bury yourself out there", to which Dr. Avison replied that he could multiply himself by training Korean doctors. "If I can train ten good doctors I will feel that my work has been worthwhile." His objectors conceded that if he turned out a lot of well-trained doctors it might be worthwhile.

The answer is that several hundred well-trained doctors have graduated from that school, and they have been the most valuable leaven in the medical profession of Korea. The Japanese trained Korean doctors, in Korea and Japan, greatly outnumbered the Severance graduates. But the Severance men have something plus, which the Cheeloo men have, character, ideals, motivation.

One of the unique features of Severance was a strong dental department under the able leadership of Dr. J. L. Boots and Dr. J. A. McAnlis.

The war dealt Severance a body blow. The physical plant deteriorated shockingly. The medical and nursing service went down with it. The organization practically folded up. The whole place was a wreck of its former self.

Miss Ruth Williams, R.N. of our Board's Medical Committee and formerly a nurse in China, visited Korea as part of the Board's deputation in 1947. She tells of the way nursing at Severance had been relegated to the level of coolie drudgery

School of Nursing at Severance Union Medical College and Hospital, Seoul, Korea. This strategic institution was very hard hit by the war and is now recovering its important place.



Preventive medicine, in this case vaccination against smallpox in Taegu, Korea, is an important part of the work of Medical Missions.



and how nurses were carrying water, for all purposes up three flights of stairs to the wards, because the plumbing had gone to pieces. Baths for patients had lapsed completely. Food was cooked in the corridors by families of the patients. The place was dirty.

Under the leadership of Dr. V. S. Lee, the new President of Severance, and Dr. A. G. Fletcher, a veteran of our Board, a concrete program of rehabilitation has been drawn up and is under way. This has been submitted to the co-operative Boards most concerned, with its appeal for funds. It is part of the aim of our Medical Emphasis Year to provide a substantial sum for Severance.

Space fails to do adequate justice to the rest of our medical work in Korea. At our maximum before the war we were operating seven hospitals at Andong, Chairyung, Chungju, Kangkei, Syenchum and Taiku and also in co-operation with the Methodists at Pyengyang. We think of the lives and personalities which have gone into the work of these hospitals, of such men as Dr. J. D. Bigger, Dr. A. G. Fletcher, Dr. Roy K. Smith, Dr. Z. Bercovitz, Dr. DeWitt Lowe, just to mention a few, and of such nurses as Miss Esther Shields, Miss Kathryn Esteb, Miss Ella Sharrocks, Miss Edna Lawrence, who have contributed so much. Of these, Dr. Bigger, Dr. Fletcher, Dr. Smith, Dr. D. Lowe and Miss Lawrence are back on the field.

Our one new medical recruit since the close of the war is Dr. Howard Moffett, son of a former missionary father, the Rev. Samuel M. of Korea.

Of these hospitals four are in the North and behind the iron curtain. Of the four in the South, Andong, Taiku and Severance are at work.

As we look ahead in the reconstruction of our Christian Medical Program, in Korea these points stand out.

- 1—Raise up again medical education at Severance. This is the long range strategy.
- 2—Do the same for nursing education.
- 3—Rehabilitate our other hospitals in the southern zone.
- 4—Co-operate with the Government in its medical program.
- 5—Facilitate postgraduate study abroad for doctors and nurses.
- 6—Emphasize certain major health problems such as tuberculosis and leprosy.
- 7—Rebuild the active evangelistic program, so characteristic of our Korean institutions, and link it up with the church. The church needs the hospital and the hospital needs the church.

If there was ever a country at a crisis, which calls for Christ and the prayer and effort of his followers, it is Korea. Communism in virulent form hangs over her, a terrible sword of Damocles. We, through our missionaries, share the threatened ground with the Korean Christians. We must stand by them and by all Korea.

JAPAN

Japan is included in our thinking as a possible potential field of medical work, though hitherto we have maintained no medical service there. This has been the policy of nearly all mission boards. It was built up years ago, on the idea that modern Japan had so advanced medically in public health and otherwise that medical missions were unimportant and unnecessary there.

This thesis has been questioned from time to time in the past and especially so since the war. For one thing it was pointed out that the Christian cause in Japan has lacked the winsome, Christward influence of a Christian hospital. For another thing, the defects in Japanese medicine have become more apparent since the war. This includes the defects in their system of medical education. There has been too much of the autocratic, rather callous, German model in hospitals and medical schools and too little real concern for the patient.

Along with all this when our imaginations have now been caught by the idea of a Christian university in Japan, the imagination goes on to a Christian medical school as part of this university. This challenging possibility has come in for careful preliminary study and will continue to be studied.

Such a medical school would of course be a major undertaking both as to financial implications and personnel implications. If done at all, it would have to be done well. It could only hope for success if done unitedly with many Christian bodies undertaking it together.

The one great present asset in view, for this scheme, which would make the venture considerably less formidable, is the possibility of using the magnificent St. Luke's Hospital as the teaching hospital. This distinguished institution, entirely spared by our bombing of Tokyo, and at present used as a United States Army base hospital, is essentially the creation of the late Dr. Rudolph Teussler and the Episcopal Church in this country. It is the outstanding exception to the above mentioned policy of not opening medical work in Japan. If this hospital were available for a teaching center it would greatly enhance the prospects of a medical school.

All that can be said now is that within the scheme of a Christian University, a medical school is receiving serious consideration.

It is greatly to be hoped that such a creative Christian project can be realized within the next decade.

BRAZIL

Brazil is the twentieth century Eldorado—the last great expanding frontier of the New World. Its immense western hinterland is growing by leaps and bounds, as our West did in the nineteenth century. This vast unoccupied country of rivers and plateaus and jungle and mountains possesses untold natural resources. Brazil as a whole contains three and one quarter square miles and in population is growing as rapidly as any country in the world. In 1890 it had only 14,000,000 population; in 1930—twenty years ago—30,000,000; today it has 41,000,000.

In other words, we have here, a tremendous formative situation in a country which will presently be one of the giants of the World. Is not this always a challenge to the Christian Church? This is the time to get in at the making.

As Brazil is the first of the Latin American countries which we are taking up, a brief general word is in order. The six countries of Latin America, with which we are particularly concerned, in common with all the other Latin Republics, have strong individualities, even with much in common. We make a mistake if we lump them all indiscriminately together. Brazil, for example, shares the general Continental European background. But it stands out as the one country with Portuguese, instead of Spanish background; and its language is Portuguese. Roman Catholicism is the powerful and predominating religious system throughout Latin America, but with marked variations of power. Brazil has its primitive submerged Indian population, so typical of South and Central America. In sharp contrast to these backward regions are the big modern cities of the sea-coast, of which beautiful Rio Janeiro is world famous.

The population of Brazil is unusually mixed and democratic. It ranges from large Italian and German colonies to negro. There is no color bar. Brazil welcomes immigration and plans to populate and develop its west country, which is rich with almost fabulous resources.

Politically, Brazil has been one of the more stable and better governed countries. There is a traditional friendship for the United States, which partly explains why Brazil actively entered World War II.

Medically, Brazil offers the contrasts which are characteristic of so much of South America. The large coastal cities, like Rio, have plenty of doctors—*not* plenty of nurses—and some modern hospitals. Up country has almost nothing. Rio is a healthy city. Up country is rife with tropical disease. If it had not been

for the magnificent work of the Rockefeller Foundation, some years ago, Brazil would probably now be overrun with yellow fever and be a constant menace to neighboring countries. It is the up country, in which we are medically at work.

We have two active hospitals in Brazil. At Ponte Nova, Dr. W. W. Wood has for many years been carrying on a work, whose reputation spreads for leagues on leagues. Until fairly recently this has been a backward and undeveloped region. It is nothing unusual to have a fever racked or hernia handicapped patient ride in for five or ten days or even more, mule back, or be carried for many days on a stretcher. The Government is now putting in an important trunk highway through Ponte Nova, which will greatly increase the accessibility of our hospital. A new plant is much needed.

At Rio Verde, far to the South, Dr. Donald Gordon, graduate of Harvard Medical School, carries on a flourishing work, which has served and grown in remarkable fashion in its twenty years span. Dr. Gordon's high grade surgical and other work has made a great place for this hospital in a very needy area.

Both hospitals have Nurses' Training Schools—under Miss Beatrice Lenington, R.N. and Mrs. Donald Gordon, respectively. These training schools have been invaluable pioneers in their field. Latin America has lagged strikingly in developing its nursing, and Brazil has been no exception. Now, through the stimulus of Protestant missionaries and other North American example and help, nursing is slowly emerging as a progressive. The Protestant hospitals are still in the lead, there again it is the impress of Christian character, which counts so much.

At Porto Felix on the great San Francisco river in the hinterland of the State of Bahia, a clinic has been started by Miss Eleanore Rodisch, R.N., a new recruit ably trained for this sort of work. When National evangelical doctors are available it is hoped that a hospital will develop here to serve this very needy part of the field.

An interesting and life-saving feature of the work in Brazil is the Mission

This airplane, given by Sunday Schools in our country, represented the vision of the Rev. Rodger Perkins, of Brazil and is one of the most useful aerial ambulances in the World.



airplane, the brain child of the Rev. Rodger Perkins, who is a licensed pilot. This plane, which was the gift of Sunday schools in the United States, is an aerial ambulance, which is constantly taking people to a hospital.

The over-arching obstacle to Medical Mission work in Brazil, as in practically all of South and Central America, is the extreme difficulty of securing licensure to practice. They want to keep out foreign competition, which goes for everyone, not just North America. They are also resentful of the United States licensure requirements when their nationals come here. As a result, their licensure requirements are virtually prohibitive. Generally speaking, we cannot send doctors to any of our missions in Latin America. Dr. Woods' arrival in the country antedated these requirements. Dr. Gordon, with extraordinary devotion and perseverance, went through such a prolonged and gruelling and precarious a procedure to secure his license that no one has attempted it since then.

Hopeful reports from the field indicate that the situation may be changed shortly.

So our future tangible contribution to Medical work in Brazil has to be through (1) nurses, (2) funds, and (3) the training of Protestant (Evangelical) doctors.

A considerable amount of Dr. Clothier's time goes into facilitating post-graduate work in one form or another for Brazilian and other Latin American doctors, who want to come to this country for postgraduate courses, internships, and observation.

These last are the long range hope. As the strong Brazilian Evangelical Church develops its outreach—its own home Mission—it is our hope and prayer that fine young doctors will offer themselves for the far reaches of this vast interior land—Eldorado in more sense than one.



The Mission Hospital at Rio Verde, Brazil, conducted by Dr. and Mrs. Donald Gordon, makes its valuable contribution in many ways, including the training of nurses. This is the hospital staff.

CHILE

We think of Chile as one of the Big Three, of "ABC" countries, of South America—along with Brazil and Argentina. It is a progressive country, with much of its life centered in the two modern cities of Santiago and Valparaiso. There is relatively little "hinterland" in this long drawn shelf of a country between the Andes and the Pacific.

The Chile medical picture is a surprising one. In spite of its progressiveness and a high-grade medical profession and good facilities in the large cities, Chile has one of the worst child mortality rates in the world. Here is where we come in.

Our medical work is chiefly at Santiago, and consists of one of our most appealing and significant pieces of medical work anywhere. This is the Maternity Hospital known as the Madre e Hijo (Mother and Child) which is the life work of Miss Marie Schultze, R.N. With nineteen beds and about 450 babies arriving a year it is a busy and useful place. Top Chilean obstetricians are on her attending staff and give their services free.

While Chile, as a whole, has an infant mortality rate of 21.7% at birth, the Madre e Hijo record is less than 2%. This makes it a great teaching institution. No wonder that the chairman of the Chile Board of Health said: "We should have twenty such institutions to teach what is being taught here." No wonder Miss Schultze has been accorded high honors by the Chilean people.

Today we are hoping for a new and larger Madre e Hijo, to extend and advance this splendid Christian contribution to the life and welfare of Chile.



The famous maternity hospital and clinic of Miss Marie Schultze, R.N. in Santiago, Chile is an outstanding demonstration in that country.

VENEZUELA

Near Valparaiso, too, Miss Rose Paden, R.N., has built up a fine Children's Clinic and Social Service Center out of which a church has grown.

Venezuela in many ways is different from most of its fellow countries of South America for it is a one resource country—oil. Everything revolves around oil. Prosperity of a sort has swept in with oil but this has its disadvantages since it is not a balanced, healthy economy. The cost of living is the highest in all South and North America.

Our mission work in Venezuela has been essentially a city work, in the attractive capital city of Caracas, which is at enough altitude to be above the tropics. The work is now expanding into the interior and a new station has been opened to reach a great rural population.

As Venezuela shares the licensure restrictions against foreign doctors, we cannot send any doctors and have no hospital. We can send nurses, however, and have started a modest clinic in one of the underprivileged areas of Caracas, with Miss Jane Evans, R.N., in charge, and Miss Mary Armbruster. This clinic, under their friendly and capable hands, has been doing general work, with special reference to women and children. Venezuelan doctors, even specialists, give of their free time to serve in the clinic—their interest is so great in what these nurses are doing. The health department of the government has been quick to observe the value of such clinics and has taken our nurses on many trips into the interior to co-operate with them in planning a rural public health program.

Apart from this clinic the nurses are active in the health supervision program of the mission schools. They reach out, too, into the homes of their pupils. They also serve in the evangelical community which, as in most South American countries, is at a disadvantage in the other hospitals and health programs.

Plans are afoot to open a clinic at the new station in the interior. Here the need is great but to meet it at least one more nurse will be needed. The North American missionary nurse is welcomed in Venezuela and is encouraged to co-operate in the government health programs.

In the land that gave birth to the Liberator, Simon Bolivar, the Father of South American freedom, an active mission health program that will eventually enlist Venezuelan evangelical doctors to the point of offering themselves for service in rural mission hospitals, should be pushed to help win the people of that land to the true freedom that is in Christ.

COLOMBIA

Colombia, if noticed by us at all, is usually thought of as a small obscure country. It is neither. It is the third largest country in South America. Moreover, it is one of the most progressive and best governed and it is one of the few countries in which the reactionary grip of the Roman Catholic hierarchy is less than decisive and dominating. It is more democratic than any of the other twenty South American republics and is open to our friendly, Christian approach. The work of our Mission, in particular, has taken on new life within the last few years, and is going forward as never before.

We are pushing forward with medical work at three points. At Barranquilla, the leading port city of Colombia, we have a general clinic, with 15 beds for in-patients under Miss Ruth Davis, and with Colombian doctors, one of whom was brought to this country for training, as visiting physicians. This clinic is a fine auxiliary for our school at Barranquilla in caring for the pupils and their families and friends, and it will reach out to serve the evangelical community of the whole coastal region.

Miss Davis has taken in four Colombian graduates from the girls' school to train as nurses. Another nurse, Miss Elizabeth Wilmot, has just been assigned to join Miss Davis in this work. It is hoped that this clinic at Barranquilla will develop into a hospital some day. The need is great for a Protestant hospital in Colombia to care for the large and growing evangelical community which is at a disadvantage in other institutions.

We are also pushing up into the unoccupied interior. The Sinu Valley has been chosen as our special pioneer venture, and Miss Linda Buller and Miss Mildred Healy are developing another interesting clinic among a predominantly Indian population at Nazaret. Both these nurses have had special midwifery training which is proving invaluable to them as the bulk of their work in this remote place is proving to be maternity work.

Miss Evalina Caldwell is returning to Colombia after her furlough to open a third clinic in the Tolimas field in the southwestern part of the country. In this region, people in great numbers are turning to the Evangelical Church so that a health program to serve the rural population of this field is urgent. Miss Caldwell is well-trained in public health and on her furlough has taken the midwifery course at the Berwind Medical Clinic, New York City.

Once more the hope of the country is through nurses and Protestant national doctors. As the Colombian Evangelical Church grows in size and impact it will have its own young doctors and nurses to pioneer for Christ in their own country. Our present clinics, without hospitals, though necessarily limited in their work, are showing the way. We are proud of what they are doing.

GUATEMALA

The little country of Guatemala, astride the thin intercontinental spine, has been called the glamour country of Latin America. It has unusual charm. It is a picturesque blend of rugged mountains and dazzling lakes, of lush jungle and quaint towns. The gorgeous upland lakes of Atitlan and Amatitlan cupped amid high volcanic ranges, are a publicist's paradise. Guatemala City is a trim and attractive metropolis and capital, mingling the old and the new. The Indian population is colorful and intriguing. Guatemala has a tradition of friendliness to our country, not always the case among our Latin neighbors.

Like the topography of their land, the people are at two levels. The city people are the Ladinos of Spanish extraction, who are the business and ruling class. The much larger rural population of the jungle and mountains are Indians, the substratum of Guatemala. They are the forgotten people. They are the hewers of wood and the drawers of water. Tourists see them chiefly as they come to town on market days, dressed in their gay and varied colors, bowed under incredible loads of produce and handicraft.

Religiously, Catholicism predominates, but is not quite as politically dominating as in some other Latin American countries. The Indians are semi-Catholic and semi-pagan. With them the old superstitious rites and the old medicine man compete with or overlap the Roman Catholic ceremonials and the priests.

The medical picture is again a contrast between the city and the country. Guatemala City has a medical school, a city hospital, and many doctors. The country, generally speaking, has none of these. The central government has an excellent public health program but its outreach is still very far from adequate.

Our one hospital, in Guatemala City, the Hospital Americano, is outstanding. Dr. Ainslie's surgical and medical work have built up an enviable prestige. The visitor who comes into the Hospital Americano from the rather unpromising street and exterior is charmed with the lovely patio. It is attractively laid out and has such an air of cheerful efficiency and helpfulness—a sunny little world of its own.

The training school of this hospital, formerly developed by Miss Matilda Smith, R.N., and others and now under Miss Nola Brown, R.N., has been one of the outstanding achievements of this hospital. For many years and until fairly recently, it was the only training school in Guatemala and the well-trained, dependable graduates were and are much sought after for responsible positions. This school might be called the keynote of nursing in Guatemala.

Another increasingly outstanding work of the Hospital Americano is its mobile country clinic, which Dr. Ainslie initiated years ago and to which Miss Lucy Bestwick, R.N., is now giving her effective effort. An excellent mobile unit

with bus and ambulance and all implementations goes out periodically to selected places for short stays of perhaps a week or two among the neglected primitive Indian people. This reaches thousands of sick folk who would never get to Guatemala City.

A new and intriguing medical undertaking is the outpost recently started by Dr. and Mrs. Calvin Wallis—Mrs. Wallis was Miss Matilda Smith, R.N., of the Hospital Americano staff—at the picturesque little town of El Rancho down the railroad and off the plateau from Guatemala City. The writer has a special warm spot for El Rancho, where he once visited the fine little school created by the Rev. and Mrs. Haymaker. It is a needy and responsive place, where medical work can be a wonderful service and influence.

The writer was much impressed, in visiting Guatemala some years ago, with the strength and value of our whole work there. Guatemala is not one of the conspicuous and strategic countries of the world, but it is a vital part of the very strategic work for all Latin America. Who knows what future Christian leaders of great power and influence will emerge from this interesting little country? And the strong medical work is a vital part of the seed which we are planting.



Hospital Americano—Guatemala—Dr. and Mrs. Ainslie and staff and visiting deputation from the Board in New York.

AFRICA

Africa is different. The people are different. Our work is different. In these days of rapid air-travel, with its shifts of scene, quick comparisons are thrust upon one. The air traveler from Asia or South America suddenly plummeted down into Africa feels a sharper contrast than he has experienced anywhere else.

We are, of course, speaking of equatorial "mid"-Africa—not North Africa, which is Arab-Moslem in culture, nor South Africa, which is a British Dominion. It is the "real" Africa, as we usually envision it—the Africa of jungles and great rivers, of the former slave trade and exploited people, of colonial or mandate governments and increasingly restive subject people.

Our work is in French Equatorial Africa, the Cameroun, on the west coast of the "middle belt."

The air traveler, from the Near East, let us say, who vaults to Africa in a matter of hours, is plunged into a new world. Instead of old and highly developed civilizations with writing, literature and recorded history, he is confronted with illiterates, with no literature and no recorded history. Their past fades quickly into legend.

This is no stigma. It has nothing to do with I.Q. The African I.Q. is just as good as anyone's. Some of us remember with admiring amazement the intellectual and linguistic feats of a self-taught African pastor, the son of a bush chief, who held us American listeners enthralled with his ideas and his English.

Moreover our flyer from Asia—and far more from Europe or America—is struck by the unhappy situation of a subject people. Asia, where it had not *staved* this off, has now *shaken* it off. The white man's empire has rapidly shrunk in the last decade. Not yet in Africa. The African is still an "under" person.

Religiously, after being with highly articulate and highly evolved systems, our sky-traveler finds himself among rudimentary religions. The people are at the animistic, pagan level. They have no god. They live in a world of evil spirits, against whom the hut must be tightly—and unhealthily—closed at night. Disease comes from these evil spirits, directly or through human channeling.

The medicine man is the all too powerful, sinister figure in this primitive African world of malign spirits and fearful influences. When disease strikes in the village he is expected to "smell out" the person who is supposed to have caused it and dictate a penalty, which may mean death.

Against all this background of the old Africa, we have powerful stirrings of new life, which were not evident two decades ago. The people of Africa are rising up against their "under" status—against racial discrimination. You may say that it is part of the world revolution of the common man and the industrial era. Even the slender, far-stretching tentacles of Communist propaganda are creeping in. Our work is in a drastically different setting than a generation ago.

The diseases of this part of Africa have been said to be more crippling than

killing. A striking exception to this generalization is the deadly African sleeping sickness (trypanosomiasis—not our encephalitis). Fortunately it is limited and localized. Yellow fever, also localized, is another killer, but, otherwise, this part of Africa runs to such diseases as malaria and yaws, which resembles syphilis, though non-venereal—and filaria, usually more harassing than serious—and leprosy, which is prolonged misery, and tuberculosis. It is surprising that we do not have cholera, plague, typhus and typhoid, those giant killers.

One of the striking facts in this connection is that all of these major African afflictions have good medical answers—either preventively or curatively, or both.

The moral is that nowadays the modern trained Christian doctor is medically well armed. He can fight to good purpose. This is a tremendous gain over the pioneer days of the last century, when so much was beyond medical knowledge.

The medical work became tremendously effective. Our clinics and hospitals were thronged with patients. In no other hospitals and clinics of our work are there such numbers of patients. Nowhere are the people more pathetically in need.

The roll call of the medical men of our West Africa mission is a roll call of stalwarts. They had to be stalwarts to win through the pioneer days. Yet, such men as Dr. Silas Johnson and Dr. Lehman lived to retirement age and left their mark. Dr. Hyman L. Weber, dynamic and indefatigable, more recently retired, was to a large extent the creator of the important Central Hospital at Elat. He was succeeded at this hospital by Dr. George W. Thorne, one of the ablest medical missionaries anywhere.

Dr. Austin R. Wolfe, the outstanding surgeon of the mission, had a part in the construction of the Central Hospital in the early days as well as the responsibility for the development of the hospital at Metet, where Dr. Evelyn Adams, the first woman doctor to Cameroun, has so ably carried on.

The other hospitals in the mission are at Sakbayeme, a work which in Dr. Clothier's very capable hands, in the 1930's, grew to almost equal size with Elat and at Bafia, Bibia, Foulassi and Metet. At the present writing (fall of 1949) Bibia and Foulassi are without an American doctor, and the eastern part of Cameroun which has been and is our responsibility is without a hospital.

These hospitals, busy, crowded, strongly evangelistic, have done a world of good. At the same time they are very much in need of improvements in plant and equipment. They should not go on as now. A non-medical board secretary visiting them a few years ago was actually shocked by their physical condition.

The training of nurses has been an integral part of the medical program. All of the hospitals engage in this program, the nurses from the smaller hospitals going to the Central Hospital for their final year of training.

One of the most interesting pieces of medical work anywhere has been the training of the African assistants. As there is no medical school in all equatorial Africa, the next best thing—and a very good second best—was to give practical, clinical training to promising young Africans. This has been done and is being done at three hospitals—Central Hospital, Sakbeyeme and Metet. A fourteen-

year course was worked out some years ago, which has been remarkably successful. These graduates are surprisingly capable. They do a lot of the work in our hospitals and carry considerable responsibility.

One of the older experienced men of this group at Elat, Bulla M'fum, who was Dr. Weber's right hand man, complained bitterly to Dr. Anderson a few years ago: "Why do you send out these raw young doctors from America? They don't know anything when they get here. I have to teach them." There was at least a grain of truth in what he said. Africa, medically, is very different from the United States and the new medical recruit has to do a lot of readaptation.

One of the crying medical needs of all equatorial Africa has been a full-fledged medical school. Africa is far behind in this. There are reasons which explain this lag—the fragmentation of Africa; the poor communications; the occasionally uncooperative European governments; the rudimentary state of all basic education, etc. But the time for a medical education program is highly due, and overdue.

We have at least the beginnings of a plan. We have a dream of a medical school and accompanying hospital in the Cameroun, at Libamba, a newly developing center of work. Libamba has certain great advantages, of good location, of being on the railroad, of plenty of population clientele who want a hospital there. The new Cameroun Christian College is an essential part of the program. This college has made a very auspicious start, as the first institution of higher learning in Cameroun. As soon as possible a pre-medical course will be added. Then we will be in a position to make definite plans for a medical school under the auspices of the Protestant Council of Cameroun and French Equatorial Africa.

The Christian doctors who come from this medical school will be a far cry from the still powerful medicine man. We are counting greatly on them to tackle the medical and public health problems of the Dark Continent and to carry the Light into these regions where it is so greatly needed.

Mobile dental clinic, Cameroun, Africa—
Dr. Theodore Shanks



The witch doctor is the bane of tribal life in Africa. It takes Christianity and medical science to displace him for something much better.



Conclusion

Finally, there is urgency, stewardship and potential. There is urgency in a critical, revolutionary, dangerous world for which Christians have the answer. There is inescapable responsibility resting on us as stewards of life and means in this favored, free America. There is also in America a tremendous financial, medical, spiritual potential for the tapping.

If this inadequate story of our medical work in the preceding pages leaves us with a feeling of complacency that what we have done is a good enough job, quantitatively and qualitatively, or that we can coast on into the future at our past pace, or if, on the other hand, it leaves the feeling that the task is too far beyond us, it will have sadly missed fire. It will have failed in its purpose.

The truth is that, though it has been a great story of which we can be humbly proud, and one in which the workers have done the utmost with what they have had, it should have been still better. It was well within the total resources of the Presbyterian Church to have established twice or thrice our number of hospitals, and, still more important, to have made them even more valuable in their qualitative excellence than they are. Right now we should be numerically better staffed, better equipped, better financed.

The urgency

What about urgency? Is there really any urgency? Or is it just "wolf, wolf" again?

Suppose we go back a bit in perspective again. A generation ago leaders like John R. Mott and Robert E. Speer and Sherwood Eddy fairly cried out to us that Japan must be Christianized—that Japan was formative, was in the critical making—that she would dominate the Far East for weal or woe—that time was running out on us—that the opportunity would pass.

We know the story. Japan was not Christianized. The war-making imperialists got control. Havoc was loosed on Asia and Europe and America. Our sons and brothers and fathers died in the Pacific. China went under, was shattered and is now a prey to Communism. Korea trembles in the balance. Southeast Asia is fearful and threatened.

If the Christian Church in the West had had a sufficient sense of urgency and mission, what might not Japan have been now! And what might not all Asia have been now!

Let it be said right here that the Protestant Church is rallying to the second critical and hopeful chance in Japan. Our Board is throwing its special strength there. Of an expected total of 75 new missionaries "budgeted" for 1950, we are planning to send 25 to Japan. This is a far larger proportion than ever before.

In some ways, India, newly freed, is at the same crossroads as was Japan a generation ago. But the pressures and hazards are greater now than then. Things

are moving faster and more momentously than ever before. Here and elsewhere we used to be dealing with slow-moving masses of people, with slow-moving religions or ideologies, with slow-moving timetables in general. All that has changed. We are now dealing with explosive, fast-moving race-conscious nationalistic masses of people—with dynamic, fast-moving Communism. The old sterile religions are increasingly beside the point. They are no longer the central issue. India has moved more rapidly in the last few years than in decades of the old order, a generation ago. India is going to be tremendously influential and determinative for the rest of Asia, outside of China.

We could go right down the line on country after country. Everywhere there are dangerous tensions, staggering problems, racial revolutions, political revolution, industrial revolution, Communism advancing. There is urgency at every turn.

Our medical part in such stupendous situations may seem small. But it is our part. If everyone does his part there is no telling what can result. Seed is planted in small, obscure ways and grows to great proportions.

"There is more healing in the dust of this place than there is in all the waters of the Ganges."

In addition to the general urgency, there is urgency in the special field of medical work. Medicine is a growing, amazingly growing, branch of human knowledge and application of knowledge. The medical nationals of these various countries are pushing ahead rapidly. They are flocking to this country for advance study by the hundreds. As we have seen, there are over a hundred young doctors here from the relatively backward, small country of Iran alone. In country after country, hospitals, medical schools and even a few schools of nursing are being developed as never before. Their financial backing from their governments is far beyond our resources. We must keep pace and advance in our medical work—our plants, our equipment, our staffing—or drop into second or third place, with disastrous effects on the Christian cause.

The responsibility

The character of our Christian institutions is their cardinal asset. But character must not be made to carry too much of the load. There must be practical implementation along with character. It should be emphasized that the people, especially in the big cities, know more, expect more, are more critical—also more appreciative of quality—and they increasingly have professional, not spiritual, alternatives which they compare with ours.

One remark in a recent letter from a very experienced and thoughtful doctor, which would apply in essence to most of our fields, is this:

"While not wishing to appear pessimistic, the writer wonders more and more what the future holds for our nursing schools. It does seem that unless something drastic is done to raise the standards of mission hospitals in the eyes of the nationals, our schools will soon be relegated to that of second class or 'practical' nursing schools."

From one of our largest and most important hospitals comes the following, which is quite typical:

"More and more in recent years the pressure on us here to meet our budget in the face of rising costs and salaries has made our approach to our patients one of finance until it has now gotten to the place where almost every day someone refuses hospitalization when it is needed, because 'I am afraid of the bills,' or 'I can't afford it.' This is very disturbing to us and it is hurting our reputation."

The financial set-up of our overseas mission hospitals should be made clear at this point:

1. In most instances the plant and original equipment have been given from America.
2. A much smaller amount of plant and equipment has in some places been made possible by receipts on the field, which means largely medical charges to patients.
3. As to current budget the hospitals, as a whole, are upwards of 90% self-supporting—from medical charges—except for the salaries of the foreign missionary.
4. Financial conditions vary greatly—from a very few favored places, where the receipts from patients have made possible capital expansion and improvement—to impoverished areas, where the receipts were quite inadequate even for minimum current expenses. The latter are much more typical.

It will be seen at once that our Board, that is, our Church, in common with other mission boards, has been asking its hospitals to do what generally hospitals in this country do not do and cannot do, virtually or largely to support themselves. Hospitals in this country—not counting the few deluxe private hospitals for the rich—depend in considerable measure on endowments, current gifts (including Community Chests) and taxes, local, state or federal. The high cost of modern medical care is implicit in this situation. The average low-income patient simply cannot pay the whole bill, even though ward rates have soared from \$4.00 a day to \$8.00, \$10.00 or even \$11.00 a day.

On top of this basic, long-accepted situation has come the higher cost of everything since the war. Most of us are painfully aware of the much higher cost of medical care, including hospital care and dentistry. Hospital administrators are put to it for the standards and even the survival of their institutions.

All this is true of the countries on a low economic level in which we are at work—only more so. It has been true from the outset of our work that a large number of patients could not pay for what they got. The hospitals had to resort to all sorts of measures to care for the poor, including charging the rich to pay for the poor. Sometimes, though not often, the hospitals were in such financial straits that they had to curtail the number of poor people admitted to clinic or ward—a most regrettable situation.

The result was that—

1. The doctors and nurses were harassed and overworked trying to keep up with this financial problem.
2. The plant and equipment were not kept up to where they should be—especially during the war period, and with the nationals progressing and making comparisons as they do now.
3. We have lost at least some of our valuable staff, because they could not stand the situation, with its financial strain, its lowered efficiency and its limitations on caring for the poor.

On top of all this “normal” problem inflation has been added; costs have gone up all along the line. To be sure, it costs less to feed a hospital patient in India or Africa than in the United States, but it costs a lot more there than it did ten years ago, or five years ago. Moreover, penicillin and operating tables and X-ray machines come no cheaper in India or Africa, etc., than they do here. In fact freight and perhaps customs must be added.

We are now trying to meet a small *part* of the problem, as follows:

1. We are aiming to raise \$500,000 in the Medical Emphasis Year of 1950—chiefly for non-recurring capital expenditures for plant and equipment improvement.
2. We have included in our current budget the sum of \$20,000 annually, to spread out over perhaps fifty hospitals to help in the care of poor patients. This was whittled down from an initial suggestion of \$100,000. It is a pathetic drop in the bucket, even though \$400 for a hospital goes a good deal farther overseas than here. But it is a step in the right direction.
3. We have included in the annual budget a sum of \$2,500 for medical journals and books for the hospitals, so that at least this factor in the keeping up of standards will be cared for outside hard-wrung hospital and personal assets.

Stewardship

What of our medical stewardship? It is a striking fact that just as world communications have so wonderfully opened up, and at the time when the world means of destruction are so stupendous, the healing powers of medicine have advanced enormously. Cholera vaccine can be flown to stricken Egypt in a day and can avert an epidemic. Medical science has the answers as never before.

The writer's medical school course was in the days of so-called “therapeutic nihilism.” Honest medical teachers freely admitted that there were only a handful of really effective drugs—quinine, digitalis, iron, a few more.

We did not have insulin. We did not know what a vitamin was. Only a few of the far-reaching immunizations which are so invaluable now, were available then. We did not have long range protection for diphtheria, or whooping cough, or cholera, or typhus or yellow fever. The first major synthetic drug, Salvarsan,

or "606," burst dramatically on our generation, but it was a long time before the galaxy of so-called miracle drugs came along. Now we have the sulfa drugs, pencillin, streptomycin, chloromycetin, aureomycin, and what not. They are a veritable revolution.

The surgeon now does incredible things. He removes part or all of a lung, without its being considered anything remarkable. He operates in ways on the brain never dreamed of in our time, removing a whole section. He even goes into the living, pulsating heart—the last "citadel" against surgery.

In the realm of prevention alone medical science can now control most of the epidemic masters of death—typhoid, typhus, plague, cholera, yellow fever. They all have answers.

It all adds up to the parable of the talents. We have a lot more to do with for sick and suffering people than we had 20 or 30 years ago. We have a lot more entrusted to us. And we are stewards of this, to a degree unprecedented.

Modern scientific medicine costs money. The Mayo Clinic is a world removed from the horse-and-buggy days of Dr. Mayo, senior, the father of the famous brothers.

A rather small college town not far from New York City is having a campaign for \$1,250,000 to enlarge and improve an already first-rate modern hospital. The whole Presbyterian Church in the U.S.A. of over two million members, is being asked, in the year 1950, for *half* a million for some *fifty* hospitals, three or four medical schools and a score of nurses' training schools. This sum is our Medical Emphasis Year goal.

The Foreign Board, as part of its stewardship, has made an intensive specialized effort to study certain areas of work in the fall of 1949, with a view to making the most effective use of the Medical Emphasis Year funds. Three people of outstanding qualifications have been sent out to study and report on (1) medical education, (2) nursing education and (3) medical social work and medical evangelistic work combined.

1. Dr. Paul S. Rhoads, a member of the Board's Medical Committee and Professor of Clinical Medicine at Northwestern Medical School, Chicago, has visited the Philippines and India, in connection with the medical education program there. This involves for us particularly Miraj, Vellore and Ludhiana.
2. Miss T. Margaret Ada Mutch, R.N., Associate Director of the School of Nursing of the Presbyterian-Columbia Medical Center, New York, has visited Syria-Lebanon, Iran, India, Thailand (Siam), and the Philippines in the interests of nursing.
3. Miss Frances Gray, of our San Francisco office, had had Red Cross medical experience during the war, has visited the same fields with Miss Mutch on rather a pioneering mission to develop a combination of better medico-social and evangelistic work in the hospitals.

The potential

The greatest tangible potential is the giving of life. The giving of life in this service, in God's service, has been the essence of the world mission of the Christian Church.

One of the most magnetic and devoted personalities ever to go into our medical mission overseas was the late Dr. Joseph Cook. After Princeton and the University of Pennsylvania Medical School he went to Iran. Though his work was then chiefly in Teheran, he visited and helped to open Meshed, when that fanatical shrine city was still largely closed to us. But it responded to him. In less than six months he had seen over 16,000 patients there.

One of his early letters from the field is aglow with his experiences.

"I've never had such satisfaction in my life. This giving sight to blind people is wonderful. A blind girl came twelve days journey—we operated on both eyes—both turned out well. Where's the sacrifice to have this privilege?"

Later, as he eagerly returned from furlough, it was found that he had early signs of tuberculosis. He returned to this country and when he recovered sufficiently, set up practice in California—but always with a longing eye for his beloved Iran.

Finally, after some years, the day came when the medical opinion was favorable. He gave up his \$20,000 practice, which meant much more twenty years ago than now, and the whole family of six enthusiastically set sail. He was assigned to Hamadan. One of the first things he did was to take a carriage and wind in and out of the lanes and by-ways of the old city till he thought he had found the poorest and neediest slum area. There he hired space and set up his downtown clinic. The people flocked to him—100, 150, 200 a day in that clinic. In the year June to June 1930-31, he treated 21,378 patients.

He was in the full tide of this abundant life when he came down with typhus—presumably from one of these patients—and died. The shock and sorrow in Hamadan and in America can hardly be described. It seemed stark loss and tragedy to have this glorious life cut off. But there was also another side.

A delegation of Moslems waited upon our mission people with an unprecedented request. It was that Dr. Cook should be buried in their cemetery. Only those who know Orthodox Islam can appreciate the force of this custom-shattering request.

They said moreover: "You have preached to us about Christ. In Dr. Cook we have *seen* Him."

"Pray ye, therefore, the Lord of the harvest—"

